

AUG 20 1917
LIBRARY
OF MEDICAL
THE

MEDICAL JOURNAL OF AUSTRALIA

(With which "The Australasian Medical Gazette," and "The Australian Medical Journal" are incorporated.)

The Journal of the Australian Branches of the British Medical Association.

VOL. II.—4TH YEAR—No. 2.

SYDNEY: SATURDAY, JULY 14, 1917.

PRICE 6D.



SPECIAL ADVANTAGES

- 1.—The close conformity in composition of the Milk Foods to human milk; both fat and proteids being in similar relative proportions.
- 2.—The readiness with which the Foods are assimilated; being as easy of digestion as maternal milk.
- 3.—Their adaptability as an adjuvant to breast feeding during the period of weaning; no digestive troubles being likely to occur.
- 4.—The freedom from all harmful bacteria; being made from fresh milk, modified, evaporated at a low temperature, in vacuo, and preserved in hermetically sealed tins.
- 5.—The ease and exactness with which the Foods can be prepared; the addition of hot water only being necessary.
- 6.—Fresh elements of diet can be easily added to the Foods, and are specifically mentioned on each tin.

A reliable substitute is thus provided for the Mother's Milk, when this is wanting or deficient

MILK FOOD No. 1.
From birth to 3 months

MILK FOOD No. 2.
From 3 to 7 months

MALTED FOOD No. 3.
From 7 months upwards

THE "ALLENBURYS" RUSKS (MALTED).

A valuable addition to baby's dietary when 10 months old and after

A descriptive Pamphlet, giving Analyses, etc., and Samples of the Foods, will be sent on request.

ALLEN & HANBURYS LIMITED
LONDON AND SYDNEY



Aquaperia

(HARROGATE, ENGLAND).

British Aperient Mineral Water

Supplants APENTA, HUNYADI JANOS,
and other German and Austrian Waters.

Editorial Note from "Lancet," March 20, 1915:

"The Water is drawn from a Spring at Harrogate. The constituents are well balanced in accordance with Therapeutic requirements."

Sold by all Chemists

Bottled by
CAMWAL, Ltd.,
at their Spring,
Harrogate,
England.

Distributing Agents: **R. E. JONES & CO.,**
Daily Telegraph Buildings. King Street, Sydney

TO THE MEDICAL PROFESSION.

We beg to state that we have received a limited number of the Ephemeris Pharmacologica for 1917 issued by Messrs. Oppenheimer, Son & Co., Ltd., London, and shall be glad to hear from any member of the Medical Profession who has not received one, and who wishes a copy, which will be sent post free.

It is a matter of regret that the necessity of keeping this Medical Diary and Visiting List a suitable size for the pocket, renders it impossible to incorporate more than a terse synopsis of the more recent publications relating to drugs. We venture to hope, however, that the 1917 edition will meet with an equally cordial reception as previous editions, and that members of the Profession will continue to favour us with suggestions for the improvement of this miniature publication.

Yours faithfully,
MUIR & NEIL.

Australian Agents,
52a Pitt Street, SYDNEY.

SECRETOGEN

(A Stimulator of Digestive Secretions)

Secretogen stimulates the production of SECRETIN, the master-key which unlocks the storehouses of the digestive juices. It is a true physiological treatment for all forms of

INDIGESTION

due to faulty gland function.

SECRETOGEN ELIXIR—half pints and pints. Dose: 2 or 3 teaspoonsful before meals.

SECRETOGEN TABLETS.—100's and 500's. Dose: 2 or 3 tablets after meals.

TRY SECRETOGEN IN SOME
STUBBORN CASE.

G. W. CARNICK CO.,
New York. London.

Samples and Literature on request from—

AYERS & JAMES PTY. LTD.
MELBOURNE & SYDNEY

THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. II.—4TH YEAR.

SYDNEY: SATURDAY, JULY 14, 1917.

No. 2.

Presidential Address.¹

By Jos. C. Verco, M.D., etc.,

President of the South Australian Branch of the
British Medical Association.

Ladies and gentlemen,—

Our Annual Meeting brings with it the duty of a Presidential Address.

It can scarcely be styled a retiring address, inasmuch as the Branch has done me the honour of putting me in the chair for another year.

The duties of the position have been happily by no means onerous, owing to the ability and method of the Acting Secretary, and devoid of all unpleasantness, through the forbearance and consideration of the Council, so that matters have run quite smoothly all the year round.

This experience in part explains my readiness to undertake the responsibility of a third year of office. One other consideration weighed with me. There are several past Vice-Presidents of our Branch, who are consequently eligible for the higher office; but the war has laid heavy burdens on them, which they are still bearing, and will have to shoulder for some time, and it seems only fair to me to ease them of this extra duty for the present, though unfortunately it withholds from them, for a year or so, the dignity of the presidency, the highest the profession can grant them.

This relief I am able to afford, and is part of "my little bit" which can be indirectly done for our Empire and its righteous cause. We will hope this strain upon our profession will have lessened before our next annual meeting, though we cannot expect it to be very greatly relaxed, and certainly not altogether removed.

Deferred Desiderata.

Some matters have been in abeyance, which, but for the war, would probably have occupied much of our time and attention.

(1) The need for legislation in the form of a new Medical Bill has been felt for a very long time; but the Government has given us plainly to understand that such a measure has no chance whatever of being introduced during the coming session. Other matters of more pressing importance—Imperial, military, financial and social—will absorb all the time and energy of the South Australian Parliament. Consideration of our professional desiderata must be postponed until a later and more convenient season.

(2) Discussion of the relation between the friendly societies and their medical officers was suspended just after the outbreak of the war, when there was no expectation of its long duration, nor any adequate conception of its effect upon the cost of drugs and other articles. Still the agreement to such sus-

pension has been adhered to, and no alterations have been demanded by the Branch, and none effected other than such as have emanated from the friendly societies themselves.

But the war has been an experience, and has made some circumstances which were latent quite manifest, arrangements are being considered so that as soon as peace has been declared, matters may be quickly, definitely, satisfactorily, and finally put upon a proper and equitable basis. Our word, however, has been given to the friendly societies—perhaps somewhat to our own financial disadvantage—that no alterations of our lodge agreements shall be forced upon them by us, and by that word in honour we bind ourselves until the expiry of the term of our promise.

Civil Honours.

We cannot but mention and record with sincere pleasure the civil honours which have been bestowed upon our *confrères* during the year.

(1) The knighthood conferred upon Dr. E. C. Stirling. As is well known, he received one of the highest scientific distinctions many years ago, viz., the Fellowship of the Royal Society, and besides this the decoration of Companion of Saint Michael and Saint George. Now he has the higher honour of his Bachelor Knighthood.

He is so versatile and many-sided a man that it may be difficult to determine with certainty for which of his various attainments and labours he has been created a Knight-bachelor. He has been a politician, and advocated principles, such as female suffrage, which were deemed Utopian and fanciful, only because he was in advance of his time and his contemporaries; now these have become incorporated not only in the laws of this State, but of the whole Commonwealth.

He has been a scientist, as his work at the Museum testifies; a paleontologist, as witness the restoration of the skeleton of the *Diprotodon australis*, and the discovery and description of the gigantic struthious bird of Australia, the *Genyornis newtoni*; a naturalist, as shown in his description and dissections of the *Notoryctes typhlops*, the marsupial mole; an ethnologist and anthropologist, as demonstrated by the magnificent and unequalled display of South Australian skulls and bones, etc., aboriginal productions, ornaments, garments, implements of peace and war, and religious emblems, which will be an enduring memorial; a physiologist, as Professor of this science at the University of Adelaide ever since the foundation of the chair; and a medical man, as a surgeon first in private, and then at the Hospital, as Dean of the Faculty of Medicine of the University for very many years, and as President of our Branch in 1888-1889, and of the Australasian Medical Congress in 1905.

I say it may be difficult to determine whether he has gained his latest distinction for his prominence in one or other of these various departments of mental energy. As, however, they have nearly all

¹ Delivered at the Annual Meeting of the South Australian Branch of the British Medical Association on June 28, 1917.

been really the outcome of his medical training, and without this scientific foundation his attainments in any of them would not have been certain, even had they been possible, we may be allowed to claim the honour as having been bestowed because he is a medical man. This is the first occasion on which a knighthood has fallen to the lot of one of our profession in South Australia for other than purely political reasons, and we congratulate our fellow-member of the Branch most cordially, and trust our hearty congratulations may enhance the value of his decoration.

The distinction which His Majesty has been pleased to bestow on Colonel W. T. Hayward comes as a delight to us all. He and the South Australian Branch of the British Medical Association are one. He may be regarded as the outstanding figure in it. He was our President in 1885-1886, our Honorary Secretary from 1897 to 1900, our Honorary Treasurer from 1900 till 1909, and our President again in 1910-1911. With manifest and significant propriety he chose as the subject of his retiring address on this latter occasion "The History of the South Australian Branch." And we remember in how interesting a manner he traced its gradual growth and development, and with what kindness and grace he recalled the names and memories of those who had belonged to it. He has been identified with the Branch since its inception, and with the profession all the time. He has been its champion when at war, and its counsellor when at peace. Many an uncongenial duty has he shouldered for the sake of the profession, where courage and tenacity were required; many a delicate task has he undertaken, where tact and care were essential, and has carried them through successfully, and we have all been drawn to him by the attraction of his obliging, unselfish disposition; so that probably no one in South Australia has more friends and fewer foes (if he ever had any) in the profession than W. T. Hayward. His estimable qualities have also impressed the profession in the other States. It was largely through his influence that the Federal Committee, from being an idea, became a fact, and it was an act as significant as it was graceful at the last session of the Federal Committee to confer upon him the unusual honour of President *in absentia*, and the parent Association at its Annual Meeting in Aberdeen elected him a Vice-President, an honour never previously conferred upon an Australian practitioner. As Lieutenant-Colonel in the Australian Army Medical Corps he has been in charge of the Hospital at Harefield, where many South Australian medical men have been under his command—if such that can be called which has seemed to them more like a fatherly direction; and from all of them has come the report of his capable organization and efficient control, exercised with the gloved hand rather than a mailed fist, so that to work under him has been a pleasure, and a happy memory. The news of his decoration was to every one of us a pleasure, but no surprise.

Our Members on Service Abroad.

We cannot but be proud of the part played by the medical men of South Australia in the great

war which is still going on. Our Principal Medical Officer has told us how completely organized the medical profession is in our State. Every man upon our register who can be upon our Reserve is on it. He has been able to meet the demands of the Director-General of Medical Services as they have arisen. And such friendly arrangements have been effected among the different areas of our State for maintaining a continuous supply of medical reserve men for camp duty, that these have been forthcoming with little or no friction or ill-will. In order to fall into line with other Branches of the British Medical Association in the Commonwealth, and to strengthen their hands we have asked the members of our Branch to vote "Yes" in the referendum, whether or not the Prime Minister shall be requested to conseribe the whole medical profession in Australia for service at home or abroad. If we vote "Yes," and the Prime Minister should accede to our wish, it will make but little difference to the profession here, who have almost to a man willingly given themselves as fully to military service as any conscription could compel.

And here we may express our pride in our younger professional brethren, who have travelled in transports with recruits to the scene of war, or home again with sick and wounded returned soldiers, who have taken up military service in our different Australian units, whether at base hospitals, casualty clearing stations, field ambulances or as regimental military officers in the fighting line. We salute the very youngest of our men, who in the Australian Army Medical Corps or the Royal Army Medical Corps have been ready to accept these last posts of special danger and risked everything but their honour and their immortality in the forefront of the battle.

We sorrow over those, happily few in number, who have made the supreme sacrifice, into whose bright young eyes we shall look no more, and whom it was our pleasant task to prepare for their life work, alas! all too short. But when this war has issued in a peace which will mean the deposition of despotism, the union of each several race into a free people, and the policing of the world, our sorrow will be lightened by the knowledge that the lads who left us for ever died for something worth this unspeakable price, bought with their blood.

Our sympathy too goes out towards those who have come back in impaired health. They went away with high hopes of doing abundant and efficient work, had prepared themselves to render aid to sick and wounded soldiers, and expected in years to come to look back and recall how many brave men they had saved, raised from sick beds, healed of their wounds, and sent back to the firing line, seasoned soldiers able to do more and better than before. But they themselves have been laid aside by the insidious invasion of germs or the fiendish inventions of Germans. We sympathize with them in their disappointment, and would cheer them with the recollection that earnest resolve and strenuous endeavour are sometimes nobler than success.

We rejoice with those who, by their unstinted labour, splendid valour, or medical and surgical skill,

have excited the admiration of their superior officers, and won their military decorations; whether it be the Distinguished Service Order, or the humbler Military Medal, or higher military rank. We congratulate them and are proud of them, and express the hope that at the end of the war, or, better still, during its continuance, many more of our courageous, capable and devoted medical men will be justly rewarded for what they have been, what they have done, and what they have suffered.

Members Who Are At Home.

Two things I should like to say with reference to these fellow-practitioners who have gone away on active service, and are still at the front.

(1) We should remember that they have entrusted us with their professional interests. They have left their practices in our hands. One can easily understand how their patients, in the absence of their own doctors, may not take kindly to the man who has been hired to fill their place, and may call in the aid of a neighbouring practitioner who has stayed at home. If they have left no *locum tenens*, as some indeed must, for their work is of such a kind as no *locum tenens* could perform, their patients must perforce distribute themselves among the doctors around. It is for us to do to them as we would be done by, put ourselves as completely in their place as we can, and display a true ethical spirit, which really means cultivate a professional conscience and follow its dictates.

There is no need to be discourteous to their patients, refuse to attend them, or fail to give them such attention as they require, or as we give to our own patients; but the interest of the absent neighbour should be carefully guarded, there should be no hint of disparagement uttered regarding him, nor any attempt made to entice them from their allegiance to him; they should be led to recognize that they are being attended only temporarily on his behalf, and until his return, and that then we will expect them to go back to his consulting rooms, or call him in when they need a visit. There is no need to tell them this during his absence, unless we are asked, but when he comes back they should be plainly told, if our services are solicited, that we are under a moral obligation not to attend them professionally now he is home. Especially does this apply to contract work, whether it be a friendly society, an insurance society, or any salaried post. The work is done in his stead and for his advantage, and the position is being kept for him, and while we do such work as well as we do any work of our own, we do it in his interests, as for one who deserves it because of the sacrifices he is making. If any practitioner could be so base as to use this opportunity for his own advantage, and to secure such position for himself, he would be a selfish scoundrel, and deserve the contempt of the profession and the lash of a tormenting conscience.

The same applies to all positions of prestige and public importance in connexion with charitable institutions, positions to which no fees and no salaries are attached, such as our hospitals and homes. Changes necessarily arise through resignations and

deaths; and so there comes a chance for the men who are on the spot to rise to positions in the absence of those who are at the seat of war, and who by right of seniority would naturally obtain them. Any attempt to "jump these claims" would be not only unprofessional but unpatriotic, and would bespeak a mean and selfish mind, and so is not to be suspected in any member of our profession. The proper course for the authorities of such institutions would seem to be, to fill these vacancies on their staff temporarily by acting physicians and surgeons, etc. They cannot be expected to appoint, at once and *in absentia*, those who are at the seat of war, who may possibly die, or be disabled, or otherwise prevented from ever taking up the work; but they can defer all permanent appointments until the war is over and the medical men have returned. Then they can distribute these honourable posts according to seniority and capacity, with a due consideration for the well-being of patients, the interests of students, and the sacrifice which has been made by the medical men who have gone to the help of the Empire at the risk of their practices, their health and their lives. It will hearten the men at the front to know their interests are being conserved by their medical brethren and close competitors, as well as by the boards of management of the institutions. We are glad to see the Adelaide Hospital management are acting upon this honourable and patriotic principle.

In an equal degree does this apply to the lecturers, demonstrators, tutors, etc., in connexion with our University. Where one of these has obtained leave of absence in order to work in the Army Medical Corps, whether Australian or British, his substitute will in honour regard himself as only his representative until the real holder of the post returns. He has a rare opportunity of showing his capacity and of developing it, and of fitting himself to be an equal or even superior successor; but he will, as an honourable man, be ready to retire in favour of his predecessor immediately on his return, and await the natural course of events to rise to the possession of the chair he has temporarily so ably filled. All absent men should be made to feel and led to know the security of the University posts they so reluctantly left, and which they so highly prize.

The Council of the Branch has striven in various ways to conserve the interests of members who are out of the State. They have sought to get agreements and arrangements among the groups of men who are in practice in certain areas; with a spirit of give and take among them, and a desire to help one another, the Council can assist. But should there conceivably be in any an endeavour to have all one's own and as much besides as one can get, to do one's own work thoroughly, and the other man's who is away only as convenience will allow rather than as conscience should constrain, the Council can help but little. Conscription and active service abroad would be a proper experience for such a person, and the easiest solution of the difficulty.

If one or more men belonging to a district should be away at the war, and a practitioner in that district should find himself very busy, because much of the work previously done by the absentee neces-

our congested tramway system, which might fittingly be styled a "feeder" to the Sydney Hospital.

In examining the table in detail, one is struck by the large total of skull fractures, averaging about two a week. This total does not include cases of accident in which the victims are found to be dead on arrival at hospital and are removed to the City Morgue. These cases are not recorded in the hospital books.

Fractures of the upper extremity account for over 50% of all fractures.

Fractures through the anatomical neck of the humerus are, as a class, doubtful. Although I have included eighteen cases, I do not think that a true fracture through the anatomical neck ever occurs.

A separation of the upper epiphysis occurs under the age of eighteen years, but an injury in this region in a patient over that age is really a fracture through the head of the humerus or a fracture through the tuberosities.

One hundred and forty-six cases of definite separation of the lower humeral epiphysis were noted. It is a very common accident in children under ten years, and is caused by a fall on the outstretched palm; in older children a similar accident causes a fracture of the lower third of the radius, or a separation of the lower radial epiphysis.

Fractures of the lower third of the radius are the most common in occurrence. Seven hundred and sixty-eight cases were seen, and about six hundred of these were examples of the so-called Colles' fracture.

Carpal fractures have been more frequently diagnosed since the routine radiographic examination of all wrist injuries. Fracture of the scaphoid is exceedingly common in tramway conductors, and might almost be called an "occupation" fracture.

I would advance as a possible explanation that these men have highly developed muscles in the forearm, due to their constant exercise on the outside of our tramcars. Consequently, when they fall on their outstretched hand they forcibly resist that hyper-extension, which all authorities agree is so necessary in the production of a Colles' fracture, and the scaphoid is forcibly driven against the lower end of the radius, and is fractured.

Fractures involving one trochanter or one condyle of the femur are not so common as one would expect, while a stellate fracture of the patella is of extremely rare occurrence.

Three cases of fracture of a sesamoid bone were seen, and I have no doubt that many more will be recorded in the future.

In conclusion, I would add a word of warning against the tendency to the teaching of exclusive dependence on radiography in the diagnosis of fractures.

The student at present is taught to put the case on a splint and then send it to the radiographic department. This is sound teaching for a man who is to have a radiographer at his side, but what of the man who will be practising in a far country town? He will be woefully at sea when confronted with some severe and obscure injury. The student should be carefully instructed as of old, and every case

of fracture should be carefully examined, preferably under an anæsthetic. He should remove all clothing from the affected part and compare it with its fellow; deformity, abnormal mobility, œdema, ecchymosis, pain and tenderness (especially if localized), loss of function and crepitus should be carefully noted and considered, in conjunction with a critical examination of the history of the case. Always let him make an attempt at diagnosis before the report of the radiographer is received, and after, let him examine the radiogram and familiarize himself with the X-ray appearances of the different commonly occurring fractures.

When available, radiography should always be resorted to. A medical man is only inviting litigation when he treats his fracture cases without X-ray examination. Damages have been awarded against many medical men recently in America for failure to have a radiographic examination made in cases of injury, in which a wrong diagnosis had been made and the patient permanently incapacitated. One such practitioner had to pay £220 in respect to a case of malunited fracture of the femur, in spite of the fact that he was 32 miles from New York and his own apparatus was temporarily out of commission.

Many errors in radiographic interpretation are possible, but they would be fewer if the observer would remember that a radiogram is only a record of a shadow. Distortion of the part in its bandages, incorrect adjustment of the tube and an oblique passage of the rays through a part all tend towards mis-interpretation.

Interpretation is everything in radiography, and a radiographer must not only be a qualified medical man, but a specially qualified one, who is constantly engaged in X-ray work.

Anyone can take the radiogram after a few weeks' practice, but it is not everybody who can interpret it.

The tube should be carefully centred over the fracture, and the rays should strike the plate at right angles to their course. Whenever practicable, two radiograms should be taken in planes at right angles to one another, as very often one radiogram will show practically no displacement, while the other will show marked displacement.

Particular care is necessary in the interpretation of injuries about the epiphyseal lines. The radiographer must be familiar with the normal appearances of these regions at all ages, and if in doubt he should always examine the sound side for comparison.

Table of Fractures.

Region.	Affected Part.	Number.	Per centage Occurrence.
A. Head	1. Cranial Bones ..	337	
	2. Nasal	41	
	3. Zygoma	4	
	4. Malar	15	
	5. Superior Maxilla..	9	
	6. Inferior Maxilla..	130	586 8.8
B. Vertebral Column	1. Cervical	18	
	2. Dorsal	7	
	3. Lumbar	17	
	4. Sacral	2	
	5. Coccygeal	4	48 .71

Region.	Affected Part.	Number.	Per centage Occur- rence.
C. Sternum		4	.06
D. Ribs		283	4.22
E. Scapula		45	.67
F. Pelvis		62	.92
G. Clavicle		252	3.76
H. Humerus	1. Upper Third—		
	(a) Anat. Neck..	18	
	(b) Surg. Neck..	123	
	(c) Others ..	47	
	(d) Epiphyseal Separation	24	
	2. Middle Third ..	78	
	3. Lower Third..	309	
	Epiphyseal Separat'n	146	745 11.12
I. Radius and Ulna	1. Upper Third..	30	
	2. Middle Third ..	176	
	3. Lower Third..	163	
	Lower Epiphysis ..	1	370 5.52
J. Radius	1. Upper Third..	72	
	Epiphysis ..	1	
	2. Middle Third ..	83	
	3. Lower Third..	768	
	Epiphysis ..	96	1,020 15.22
K. Ulna	1. Upper Third—		
	(a) Olecranon ..	77	
	(b) Others ..	19	
	Epiphysis ..	5	
	2. Middle Third ..	48	
	3. Lower Third..	67	
	Epiphysis ..	1	217 3.25
L. Carpus	1. Scaphoid (O. Na- vicular)	153	
	2. Semilunar (Luna- tum)	2	
	3. Trapezium (O. M. Majus)	6	
	4. Trapezoid (O. M. Minus)	2	
	5. Magnum (O. Capi- tatum)	6	
	6. Pisiform... ..	1	170 2.23
M. Metacarpus	Fractures ..	661	
	Epiphyseal Separat'n	2	663 9.9
N. Phalanges		315	4.7
O. Femur	1. Upper Third—		
	(a) Neck ..	118	
	(b) Pertrochan- teric	23	
	(c) Trochanter only	8	
	(d) Others ..	34	
	2. Middle Third ..	102	
	3. Lower Third—		
	(a) One Condyle only	6	
	(b) Others ..	62	
	(c) Epiphysis ..	6	359 5.35
P. Patella		53	.8
Q. Tibia and Fibula	1. Upper Third..	25	
	2. Middle Third ..	102	
	3. Lower Third..	199	
	Epiphysis ..	6	332 4.95
R. Tibia	1. Upper Third..	33	
	2. Middle Third ..	103	
	3. Lower Third..	140	
	Epiphysis ..	13	289 4.31
S. Fibula	1. Upper Third..	17	
	2. Middle Third ..	18	
	3. Lower Third..	288	
	Epiphysis ..	4	327 4.9
T. Tarsus	1. Astragalus (Talus)	22	
	2. Os Calcis ..	53	
	3. Navicular ..	11	
	4. Internal Cunei- form (Pr.)	8	
	5. Middle Cuneiform (Sec.)	1	
	6. External Cunei- form (Ter.)	4	

Region.	Affected Part.	Number.	Per centage Occur- rence.
	7. Cuboid ..	9	
	Separation of Epi- physis of Os Calcis	2	110 1.64
U. Metatarsus	Fractures ..	295	
	Epiphysis ..	2	297 4.43
V. Phalanges		150	2.23
W. Sesamoids		3	.04
		6,700	99.9

Reviews.

PSYCHIATRY.

An acceptable and reliable work on mental diseases and disorders making an appeal alike to the student, the general practitioner and to the specialist in this branch of medicine is the fourth edition (1916) of the "Manual of Psychiatry," by Drs. J. Rogues de Fursac and A. J. Rosanoff. The first-named author is the Chief of the Public Insane Asylums of the Seine Department, France, while Dr. Rosanoff, who is responsible for the present revision and extension of the original French issue, is First Assistant Physician, King's Park State Hospital, New York.

The authors are to be congratulated on the common-sense manner with which they have approached and dealt with their subject and its many problems, and they are to be felicitated also on their directness and simplicity of expression. This manual, unlike many similar books issued of late in America, is refreshingly easy to read and informative. One does not require to have at elbow a glossary of freakish pseudo-scientific terms, mostly of German origin, in order to read and understand this book. It displays throughout its 504 pages evidence of shrewd observation, clear thinking and well-reasoned opinions; it subscribes to no particular school of fashionable psychiatric teaching. For instance, it mentions but briefly the far-fetched and fantastic theories of the psycho-analysts, and by reason of this healthy (i.e., sane) attitude, the authors must commend themselves to their English-speaking readers, quite apart from the intrinsic merit of their work. The manual, which is carefully and well printed, is divided into two sections. One half of the book is devoted to a study of general psychiatry, and deals with the causes, symptoms, treatment and, what is more important than all else, the prevention of mental disorders. In the latter half of the work the various forms of mental affections are described in detail, the classification of Kraepelin being followed closely—a classification that has displaced most others for the present. With regard to the aetiology of mental disorders, the writers indicate that there are what are called "essential causes" (few in number) and "incidental or contributory causes" (a legion). The former are stated to be heredity, alcoholism, syphilis and head injuries. In dealing with heredity the authors give a concise and clear account of the Mendelian theory. Three most interesting and useful chapters are devoted to an illuminating study of disorders of perception, disorders of consciousness and disorders of affectivity. Under these headings are found hallucinations, illusions, defects of memory, association of ideas, disorders of judgement (delusions), and cognate matters. These subjects are dealt with in a most able manner, and much original thought has been bestowed on their elucidation. These chapters are, without any detracting from the work as a whole, perhaps the best in the manual, and in an attractive and easy manner they place at the disposal of the reader authoritative and recent knowledge of a large and important group of intricate morbid mental symptoms. This part of the book holds as much attraction for the general practitioner as it does for the specialist. Several chapters, dealing entertainingly with the practice of psychiatry, appeal more particularly to the specialist. They

¹ Manual of Psychiatry, by J. Rogues de Fursac, M.D., and A. J. Rosanoff, M.D.: 1916. New York: John Wiley & Sons, Inc.; London: Chapman & Hall, Limited; Fourth Edition, Revised and Enlarged; Demi 8vo., pp. 552; Illustrated. Price, 10s. 6d.

contain a useful scheme for taking histories, and describe a good routine method of clinical examination; special and modern diagnostic procedures are exhaustively discussed, and included is a clear exposition of the Binet-Simon tests with illustrations. A helpful method for the examination of aphasia, particularly with reference to estimating the testamentary capacity of aphasics, is incorporated in these chapters. The rationale of the Wassermann reaction, the examination of the cerebro-spinal fluid, the colloidal gold test and the ammonium sulphate test all receive detailed description. This division of the book concludes with a consideration of the management and treatment of mental disorders on thoroughly practical lines, and questions of prognosis, the prevalence and prevention of mental disorders are taken into review.

The authors maintain, with reference to the prevention of insanity and allied states (the chief goal worth aiming at), that "Dissemination of knowledge (as to causation) should only be regarded as a preliminary step which will make possible the application of larger measures by society as a whole, and nothing short of that will constitute an effective system of mental hygiene." That devastating triumvirate, syphilis, alcohol and the unfit, must be vigorously assailed by legislation if any good, rationally speaking, is to be attained. Our existing methods of dealing with insanity and other mental defects are deplorably stupid and woefully inefficient. The final chapters of the manual, covering 280 pages, are taken up with a detailed and well-ordered description of the various forms of the insane state, and with their course and treatment. Herein is to be found an amount of carefully-compiled and accurate information, sufficient to satisfy the needs of the most exigent student, and written, very obviously, with first-hand knowledge by two authorities who are thoroughly conversant with their subject. References to nearly 300 authors are made in footnotes throughout the book.

University Intelligence.

THE UNIVERSITY OF SYDNEY.

A meeting of the Senate of the University of Sydney was held June 11, 1917, at University Chambers, Phillip Street, Sydney.

Professor F. Anderson and Mr. M. Atkinson were elected as the two representatives of the University on the Central Council of the Workers' Educational Association.

The Vice-Chancellor (Dr. Cecil Purser) and Mr. J. J. C. Bradfield were appointed trustees of Wesley College representing the University.

The following recommendations, forwarded by the Joint Committee for Tutorial Classes, were adopted:—

1. That the recently formed Tutorial Class for women at North Sydney, for the study of history, be approved by Senate, and that Miss M. C. Collisson, B.A. be the tutor.
2. That Miss E. Skillen, M.A., Lecturer in Literature, Teachers' Training College, be appointed as tutor in Literature in the Department of Tutorial Classes.
3. That the new class in Literature at Wills' Tobacco Factory be approved, with Miss Skillen as tutor.
4. That Miss Zoe Benjamin, Lecturer in Psychology at the Kindergarten Training College, be appointed Tutor in Psychology in the Department of Tutorial Classes.
5. That a recently-formed tutorial class in "Child Study" be approved, with Miss Zoe Benjamin as Tutor.

Draft by-laws and regulations were adopted on the recommendation of the Joint Committee for Tutorial Classes.

A meeting of the Senate of the University was held on July 2, 1917, at University Chambers, Phillip Street, Sydney.

A letter was received from Judge Curlew resigning the lectureship in the Law of Procedure, Pleading and Evidence. The resignation was accepted, and it was resolved that the Senate place on record an appreciation of his services rendered. Professor Peden reported that, with the authority of the Chancellor, he had asked Mr. J. Meillon, M.A., LL.B., to undertake the lectures temporarily. The Senate gave its

approval of the action taken, and it was resolved that applications be invited for filling the position as from the commencement of Michaelmas term.

A letter was received from St. Paul's College, nominating Mr. F. A. A. Russell, M.A., and Mr. A. B. S. White, B.A., as trustees of the sub-grant of land. In regard to the request of the College that the Senate nominate two trustees in accordance with the deed of grant, the Vice-Chancellor and the Hon. Mr. Justice Street were appointed.

A letter was received from Mr. H. Dunstan Vane, resigning the office of lecturer in Accountancy, on account of pressure of work. It was resolved that the resignation be accepted with regret, and a letter expressing appreciation of his services be forwarded to him.

A letter was received from Assistant Professor Chapman, resigning his position in the Department of Physiology, and it was resolved, on the motion of Sir Thomas Anderson Stuart, that Assistant Professor Chapman's resignation be accepted with regret, and that a letter be sent expressing appreciation of his services to the University.

On the recommendation of the Professorial Board, it was resolved:—

(1) That Mr. W. A. Miller, B.Sc., Lecturer and Demonstrator in the Department of Engineering, be admitted *ad eundem gradum* to the degree of Bachelor of Engineering in Civil Engineering. Mr. Miller holds the degree of Bachelor of Science in Engineering and Mechanics of the University of Glasgow.

(2) That the regulations for 1915, which applied to students volunteering for active military or naval service abroad, be continued for this year in the case of students of less than three terms' standing; and that heads of departments be empowered, at their discretion, to arrange special examinations for students of other years, either at the end of Trinity term or later.

Vital Statistics.

TASMANIA.

Hobart.

The Government Statistician of Tasmania issues the vital statistics each month, the figures obtaining in respect of Hobart and Launceston being grouped as urban figures, while the country figures are kept separate. The following data cover the period of April and May. There were 213 births registered in the Hobart district, which has a population of 39,632. The birth-rate was therefore equivalent to an annual birth-rate of 32.64. The number of deaths in Hobart was 88, and the equivalent annual death-rate was 13.3 per 1,000 of population. Nine infants under one year of age died, and the infantile mortality was therefore 85.7 per 1,000 births. The chief causes of death are given in tables under groups such as general diseases, etc., while in a second table an abridged classification is given. There were 20 deaths due to affections of the cardio-vascular system, 6 due to tuberculosis, 8 due to cancer, 2 due to cerebro-spinal meningitis, 2 to simple meningitis, 1 to diphtheria and 2 to gastro-enteritis.

Launceston.

The number of births registered in the Launceston district was 128. The birth-rate was equivalent to an annual rate of 31.2 per 1,000 of population. The number of deaths recorded during the two months was 41, and the equivalent annual death-rate 10. Three infants under one year of age died, and the infantile mortality was therefore 23.4 per 1,000 births. Of the 41 deaths, 4 were due to tuberculosis, 6 to cancer, 7 to affections of the cardio-vascular system, 4 to diphtheria, 1 to enteric fever, 2 to pneumonia and 2 to gastro-enteritis.

Country Districts.

The number of infants born in the country districts of Tasmania during April and May was 530. The birth-rate, expressed as an annual rate, was 23.3 per 1,000 of population. The number of deaths recorded was 135, and the death-rate, expressed as an annual death-rate, was practically 6. Of the 135 deaths, 37 were due to so-called general diseases, including 12 from tuberculosis, 13 from cancer, 4 from diphtheria, 3 from diabetes and 1 from dysentery.

The Medical Journal of Australia.

SATURDAY, JULY 14, 1917.

Co-operation and Co-ordination.

The time is past when the function of the medical practitioner was limited to the care of individual patients. Little by little the assistance of the private practitioner has been sought and gained for purposes connected with preventive medicine. The evolution of hygiene has been marked by stages, each one dependent on the association of a fresh expert with the conclave of hygienists. Formerly public health officials were content to supervise more or less efficiently the carrying into effect of sanitary laws and those controlling the movements of persons suffering from infective diseases. With the advent of serious endeavours to check the spread of disease came the efforts on the part of the legislature to regulate the hygienic conditions under which the citizens lived and to apply general principles of preventive medicine to the whole community, while the individual practitioner was required to fashion his practice in harmony with these general measures. The creation of health ministries, the introduction of national insurance in England, and the recent legislative enactments to stamp out certain infective processes have all developed as a direct result of an increased knowledge of the aetiology and prophylaxis of disease. The results which have attended these official and semi-private efforts to stem the ravages of disease and to improve the general health of the community have been sufficiently striking to justify the means utilized. We have experienced a distinct reduction in the incidence and mortality rate of tuberculosis, in the general death-rate and in the infant mortality rate in all civilized countries during the last three decades. Unfortunately the benefit attending these efforts has not been uniform throughout the world. The reason is not far to seek, for it is evident that the effort has been better organized and more energetically applied in some countries and cities than

in others, and the persons directing and actually applying the prescribed measures have been better equipped for the tasks in some places than in others. Incidentally it is necessary to recognize that one of the most serious obstacles which have to be overcome is that arising out of the tendency of ministers of public health to use preventive medicine as a peculiarly fertile field for electioneering purposes. Australia has witnessed in the past too many propositions dealing with hygiene which have been evolved for the purpose of pleasing the elector rather than of improving the general health.

The Committee appointed by the Department of Trade and Customs for the purpose of enquiring into the causes of death and invalidity have wisely impressed the public with the necessity of an organized campaign to check tuberculosis, diphtheria, venereal disease and the contributory causes of a high infantile mortality. The practical advantages of a satisfactory sanitary control has been demonstrated in Great Britain, where enteric fever has been almost eliminated. The improved housing conditions and control of the milk supply have effected a marked reduction in the mortality from tuberculosis in Great Britain within recent years, and these efforts have been supplemented by co-ordination schemes, such as that devised by Sir Robert Philip, of Edinburgh. The public health authorities in Edinburgh are making an effort to devise measures to conserve the health and lives of young children, and the result has been the introduction of a maternity and child welfare scheme in which co-ordinated work is planned. Briefly summarized, this Edinburgh scheme depends on the collaboration of the Public Health Committee, Medical Officer of Health, a special Medical Superintendent, and the medical profession generally. The idea consists in a co-ordination between the Public Health Department, antenatal home visiting centres, maternity centres, schools for mothers, dispensaries and general practitioners, institutions for the care of the parturient woman, with a system of home visitation, homes for unmarried mothers and their babies, hospitals for mothers and babies, child welfare centres, milk depôts, day nurseries, etc., dispensaries, cripples' homes, convalescent homes and children's shelters, and lastly, the institution for

sick children and mental defectives. With this is linked the care of school children under the guidance of the education authority. The proposal cannot be successful unless the general practitioner is prepared to work together with the various agencies and apply the same measures to his private patients as are applied to the indigenous section of the community through the public agencies. The scheme takes into consideration the necessity of the co-operation of specially trained physicians, pathologists, bacteriologists, obstetricians, sanitarians and administrators. Not long ago a criticism was levelled against the British national insurance scheme that, since no provision had been made for the service of the best specialists being secured, the insured individual did not get a fair deal. No great and all-embracing scheme for the provision of individual treatment can ever produce the same results as a scheme of co-operation and co-ordination between public health authorities and medical practitioners in public and private practice, including specialists. The danger of proposals like the Edinburgh tuberculosis and child welfare co-ordination schemes lies in the multiplication of agencies and in the exclusion of the general practitioner as a free co-operator. If the profession as a whole can regulate itself, so that prophylactic measures can be applied by general practitioners in the course of their private practice as an integral part of the general scheme, we feel that better results will accrue than nationalization or national insurance could secure.

MOBILIZATION IN NEW ZEALAND.

The New Zealand Branch of the British Medical Association recently put forward several proposals dealing with the supply of medical practitioners for war purposes and for civil practice. The fundamental arrangement asked for is that the military and civil authorities should be guided in the distribution of medical men by an Advisory Board to consist of six members of the Branch of the British Medical Association. The Board would have functions similar to those of the British Central Medical War Committee and the Committee of Reference, and to the committees which acted for a short time in Aus-

tralia after the Proclamation of September 29, 1916. The second proposal of the New Zealand Branch is that newly qualified and registered practitioners should be required to place their services at the disposal of the Minister of Defence in the first place, and if he does not avail himself of these services, the Minister of Public Health should have the disposal of the men. It is stated that the Minister of Public Health is anxious to secure the services of these young practitioners for hospitals and mental hospitals. The New Zealand Branch further proposes that medical practitioners engaged in private practice should be prevented from changing the place of their practice during the period of the war without the permission of the Minister of Public Health. It is not clear to us whether it is suggested that legislation should be introduced for this purpose or whether some arrangement should be arrived at between the Minister of Defence and the Minister of Public Health, whereby the latter could have control of civil practitioners, in so far as the place of practice is concerned, and in the event of difficulty the Minister of Defence could call up a refractory practitioner for military duty. The method adopted in Great Britain appears to us to be more acceptable to practitioners. The Committees having charge of the enrolment of practitioners direct, as far as may be necessary, the movements of private practitioners. The interests of the civil community are safeguarded with the least amount of dislocation of the ordinary practice of doctors, and since these committees are composed of medical men, there is no fear of hardship being inflicted on anyone. To place the destiny of medical practitioners into the hands of a Minister of Public Health would not meet with approval in Australia. The explanation for this suggestion is contained in a scheme for the financing of the arrangements to keep up an effective medical service for the civil community. The New Zealand Branch has expressed the opinion that the Government should advertise for medical practitioners to take over the care of the people in districts at present supplied with too few doctors, offering them, in addition to what they can earn, an honorarium of £560 per annum, which is the pay of a Captain. The Government has made a counter-proposal that they will subsidize these medical practitioners to an

extent necessary to bring their incomes up to £600 per annum, and, in addition, that they will allow them £100 for travelling expenses. It would thus appear that since the Branch has invited the Government to bear the cost of maintaining an efficient medical service for the community, it was felt that the Minister of Public Health should be chosen as the arbiter in the event of a practitioner desiring to change the place of his practice. Even if this be so, we still regard the proposed arrangement with distaste. The Government gives the medical profession nothing. It pays at times for valuable services. The moment the medical profession resigns full control over its own conduct difficulties and troubles may be anticipated. It has been held in Great Britain and in Australia that the licensing bodies and the bodies which have disciplinary powers over registered medical practitioners should be purely professional. Even when a medical man enters the public services, he is still required to act in accordance with the ethics of the profession. The General Medical Council can remove the name of a medical officer of a Government Department from the medical register for infamous conduct in a professional respect, and the determination of what constitutes infamous conduct in a professional respect has been determined by the Council, and has received confirmation in courts of law. It would, in our opinion, be more in keeping with the custom of the medical profession if the permission to change the place of practice were obtainable from the professional committee controlling enrolment for enlistment, rather than from a Minister. The medical profession can maintain cordial relations with the Minister without relinquishing to him any of its zealously guarded rights.

VOLUNTARY ACCELERATION OF THE HEART.

It is well known that some persons retain the power of contracting at will certain muscles of which the majority of mankind have lost control. It is less widely known that a very few persons possess the capacity of influencing muscular activities which are commonly regarded as entirely beyond voluntary regulation. Medical literature contains a few records of individuals who have been able to accelerate the rate of the heart beat. A recent examination of this rare phenomenon has been made

in two persons by J. Favill and P. D. White.¹ The subject of the larger number of their experiments was a man of thirty years of age who had never exhibited any symptoms or signs of organic heart disease. In 1911 he accidentally produced the sensation which was afterwards found to accompany the acceleration of the heart beat. In 1913 the discovery of the rapid heart beat was made while inducing the sensation. The subject accelerates the heart beat within one second of willing it, increasing the rate of the heart by 30 to 60 beats per minute. The acceleration can be maintained for 30 seconds. A feeling of "fullness" and tingling over the whole body accompanies the tachycardia. Distinct relief is felt on relaxing the will, and moderate fatigue follows the paroxysm.

Since the researches of the late W. H. Gaskell the contraction of the cardiac muscle has been considered myogenic in origin. In recent years it has been rendered probable that chemical substances in the blood initiate changes in the components of certain muscle units, leading to the physical processes constituting the muscular contraction. However the beat of the heart is produced, it has long been known that its rhythm is controlled, *inter alia*, by nervous impulses traversing both the pneumogastric nerves and the cardiac branches of the sympathetic system. The vagal nerves convey, more or less continuously, nervous impulses which regulate the speed of the heart. When these impulses follow one another less frequently or, perhaps, when the degree of excitation is weaker, the cardiac contractions occur more rapidly while the heart beats are restrained with more pronounced vagal stimulation. The vagus nerves have been well named the reins of the heart. The cardiac nerve fibres of the sympathetic system convey impulses which accelerate the rate of the heart, though we are not so well acquainted with the conditions under which these fibres operate in the healthy man. Voluntary acceleration of the cardiac rhythm might be occasioned through either of these nerves.

Electrocardiograms show that the speeding up of the heart is due during voluntary acceleration to a diminution of the length of diastole. The record of the systole shows little, if any, difference from that obtained under ordinary circumstances. When atropine is administered, the heart beat increases in half an hour from 82 to 105 beats per minute. An electrocardiogram reveals no change in the relations of the various waves, but the diastolic pause is diminished. Voluntary acceleration occurs immediately upon willing it, despite the paralysis of the vagal nervous termination by atropine. The electrocardiograph shows no change except a further diminution in the interval of diastole. It was noted that the pupils of the eyes became dilated when the subject willed the cardiac acceleration. These observations suggest that the subject possesses the power of exciting the sympathetic nervous mechanism, and, in this way, increases the speed of the heart. It has been found that the systolic and diastolic blood pressures are both raised by the rapid cardiac contractions, and that the pulse becomes markedly di-

¹ *Heart*, Vol. VI., January, 1917.

erotic. On two occasions the subject was able to ward off attacks of faintness by willing an increased heart rate, and thus derived benefit from his rare accomplishment.

Some additional observations were made on the subject investigated by Pease² in 1889. More than twenty years had passed since this man had attempted the feat, but he proved his ability to hasten his heart-beat at the first trial. Electrocardiograms showed similar features to those mentioned *supra*. The dilation of the pupils of the eyes, which was not observed by Pease, is synchronous with the voluntary acceleration.

THE VICTORIAN BRANCH AND THE FRIENDLY SOCIETIES.

A statement was made at a meeting of the Trafalgar Druids' Lodge in Williamstown on June 25, 1917, by a Past Grand President to the effect that the Victorian Branch of the British Medical Association had delivered an ultimatum to the lodges, demanding increased pay for medical attendance on lodge members amounting to £39,437 10s. The speaker attempted to show how greedy the doctors are and what magnificent patriots the lodges are. It is unnecessary to follow the speaker through his arguments, since they represent a type to which medical practitioners have become accustomed. Dr. D. Rosenberg was tempted to take up the questions raised, and embarked on a polemic in the *Age* with the usual anonymous Friendly Society Member. It is not our practice to take notice of unsigned correspondence in the daily press, and pending the completion of the negotiations between the Victorian Branch and the Friendly Societies it would be highly undesirable were we to express any opinion on the subject at issue. We are, however, constrained to make a slight departure from our usual practice and to make a very definite statement concerning the relation between lodge patients in general and medical officers of lodges during the continuance of the war. The medical profession has earned the reputation of being generous to a fault and of giving medical attendance to persons in stringent financial circumstances. Contract practice was introduced for the purpose of enabling persons of small means to secure medical attendance without having to rely on charity and without owing the doctor sums of money they could not pay. The doctors agreed to attend to persons of small means who paid a small contribution regularly throughout the year, although this form of practice could never be remunerative, since it entails much work, and the rates are fixed not in accordance with the work done, but in accordance with the means of the subscribers. At best it is a concession on the part of the medical practitioner. The Lodges are required to keep their members "financial" when they are serving the country with the Australian Imperial Force. This can be done by means of a levy and in other ways, and in no case is the financial prosperity of the Friendly Societies embarrassed by this arrangement.

It is therefore manifestly unfair for the management of the Friendly Societies to ask the doctors, who have been assisting them to establish the lodges firmly in the past by rendering cheap but efficient service, to lower the rates because of the war or to defer a demand for an increase of rates measured in accordance with the means of the members. Even if the doctors in Australia were so inclined, they would not be justified in doing this, since those medical practitioners who are serving abroad in many cases would be heavy losers. There are many instances in which a doctor has joined the Australian Imperial Force as a member of the Army Medical Corps and has to pay out of his Captain's pay his house rent, the expenses of his practice and the domestic expenses of his wife and children. Too often there is steady loss, which would be increased if his lodge rates were cut down or kept at the old sweating level. The landlord has not hesitated to keep the rent up to current rates; the tradesman charges full value both to the doctor and to the lodge members for all the wares supplied. Why should the doctor be singled out for compulsory charity under the guise of lodge practice? The question which the Victorian Branch is now taking up is a business one, and sentiment cannot be introduced with equity. As we have already stated, the doctors have but little to negotiate about. The terms of the Model Lodge Agreement are reasonable terms. Anything less would react unjustly on their neighbours in New South Wales.

THE AUSTRALIAN ARMY MEDICAL CORPS COMFORTS FUND.

We have received two further subscriptions to the Australian Army Medical Corps Comforts Fund. Up to the present, seven members, out of a total of 2,500, have sent donations.

	£	s.	d.
Amount previously acknowledged	12	12	0
Dr. W. H. Read	5	0	0
Anonymous	2	2	0

Medical Societies.

THE OPHTHALMOLOGICAL SOCIETY OF NEW SOUTH WALES.

A meeting of the Ophthalmological Society of New South Wales was held in the Sydney Hospital on May 2, 1917. Dr. Cyril Shepherd, the President, in the chair.

It was proposed by Dr. Hughes and seconded by Dr. Halliday, and carried, that the Secretary be instructed to write to the New South Wales Branch of the British Medical Association that in reference to a Bill to amend the Medical Practitioners' Act which had been announced steps should be taken to prevent the use of the term oculist or other misleading designations by other than legally qualified medical practitioners.

Dr. E. A. D'Ombrian showed a case of an adult male suffering from a high degree of *myopia*. His vision was very poor in the right eye, but he only discovered this on lens opacities developing in the left eye. Upon examination there was a large myopic coloboma and white patches in the fundus, which he thought projected forwards. There was a large white patch extending downwards and outwards, and ending in a tail-like extremity. It was questionable whether this was congenital coloboma of the choroid or some organized exudate. In addition, there were extensive macular changes.

² Boston Med. and Surg. Journ., Vol. CXX., p. 525, 1889.

Dr. R. H. Jones agreed with Dr. D'Ombrian that it was a case of excessive degenerative changes typical of a myopic eye.

Dr. S. Hughes was of opinion that there was nothing beyond the ordinary atrophic changes found in high myopia.

Dr. J. C. Halliday was of opinion that the white area below might possibly be a congenital coloboma. He would have expected the tail-like extremity to be directed downwards and inwards rather than downwards and outwards, if this were the case. He referred to an article in the *Archives of Ophthalmology*, in which the author expressed as his opinion that myopia was a disease which was intractable to treatment, and which ran its predestined course irrespective of the wearing of glasses, and irrespective of occupation demanding constant use of eyes for near work or not.

Dr. C. Shepherd thought Dr. Halliday's mention of the article on myopia extremely interesting; he personally had found at least a large proportion of his myopic cases intractable to treatment by correction with glasses and abstaining from work requiring near vision.

Dr. R. H. Jones exhibited a silver eye-ball, which in its manufacture had had many perforations made in it, and which had been put into Tenon's capsule 16 years ago in Adelaide. A short time ago the patient came to him with argyrosis of the socket, considerable irritation of the socket, and complaining of pain. He advised the patient not to wear the shell prosthesis for a week or two. However, the pain increased and became very severe indeed, and as a portion of the ball was visible, he instilled cocaine, enlarged the opening in the conjunctiva, and attempted to remove the ball by inserting a probe into one of the apertures of the ball and drawing it forward. To his surprise, he was quite unable to remove it in this way. Later he removed it under chloroform, and found great difficulty in so doing. It was necessary to snip right round the ball with a pair of curved scissors and to cut through numerous bands of connective tissue which were growing through the apertures in the ball. The ball was occupied by masses of connective tissue or organized exudate, portions of which were projecting through the apertures. He thought it was a very unusual and interesting case. In this case the other eye was blind. There were posterior synechiae and a lens opacity, and projection was very bad. This was of interest, as there was no history of any attack or any inflammation or pain in the eye. The patient merely complained that his vision began to fail recently after a lift accident. He was very reticent, and would not give any more information.

Dr. E. Temple Smith cited a somewhat similar case. The patient had complained of irritation in the socket, in which he had had a glass ball inserted into the sclera by Mules' method 25 years previously. He found spicules of glass protruding, and eventually he removed the scleral remnants, which enclosed a large number of elongated fragments of glass, the ball apparently having disintegrated. An experienced instrument man at one of the hospitals had informed him that a glass ball was much more likely to disintegrate in this way if it had been sterilized by boiling, than if it had been sterilized by immersion in lysol. He personally preferred Frost's to Mules' operation.

Dr. C. Shepherd said he had had difficulty in keeping in the glass balls in Frost's operation. He had only done it a few times, but was not pleased with the consistency of the results.

Dr. Guy Antill Pockley stated that he rarely did an ordinary enucleation. He thought Frost's operation was preferable to Mules', as it was free from the slight risk of a sympathetic involvement of the other eye, which existed in Mules' operation. He had done a large number of these operations, probably between 30 and 50, and in only two cases had the glass ball been extruded. He had sutured Tenon's capsule with catgut only in these two cases. He thought that there were several important points in technique to remember. Firstly, the greatest care should be exercised in cutting through Tenon's capsule, to divide it as close as possible to its insertion to the globe. No attempt should be made to cut the muscle tendons separately; the surgeon could prevent the ball slipping to one side, which took place when the capsule was clumsily freed from the

globe or button-holed. The ball should not be put in until all hemorrhage had been arrested; a swab should be packed in for a few minutes, and Tenon's capsule should be freed thoroughly from the conjunctiva. Tenon's capsule was closed with mattress sutures of silk, and the conjunctiva with interrupted sutures, the raw edge being turned inwards, so as to secure a smooth socket.

At the request of the President, Dr. E. A. D'Ombrian described the steps of an operation which he had found extremely successful in one case of contracted socket, where no lip had been formed by the lower lid which would retain the artificial eye. In this case the operation was highly successful, though in another case it had met with failure.

In this operation he incised the conjunctiva horizontally as far back in the socket as possible; he then made two small incisions forwards from the lateral extremities of the incision; he freed the conjunctiva and drew it forwards as a flap. An assistant held it in this position, while he cut through as much of the tissues underneath as he could, making his incision as close to the skin of the lower lid as possible. Then he drew the tissue backwards, turned the flap of the conjunctiva backwards into the recess thus formed, and this left a raw area denuded of conjunctiva, which had originally been covered by the flap. This he covered with a large piece of the mucous membrane of the lip, which he stitched into place; three sutures were passed deeply downwards and forwards through the skin of the cheek, where they were knotted over a bead or piece of rubber tubing.

He thought the operation was worthy of trial in similar cases, which were notoriously difficult to cure, as he had achieved such complete success with one of his two cases.

Dr. J. C. Halliday reported a case of *convergent strabismus* in a child of five months. The squint was of such a degree that in neither eye could any sclera be seen to the nasal side of the cornea. As far as he could ascertain, the strabismus was due either to paralysis or to absence of the external recti. He had hesitated to do anything with this case, but yielded to the urgent request of the parents, and tenotomized both internal recti.

Dr. R. H. Jones and Dr. S. Hughes mentioned that they would not have operated at all. Dr. Hughes was of opinion that, had the case been left, later on it would probably have proved to be an ordinary concomitant strabismus.

Dr. E. Temple Smith was of opinion that if any operation had been deemed advisable, an effort should have been made to find the external recti and advance them rather than to perform tenotomy.

A general discussion followed on the propriety in squint operations of doing a complete tenotomy or a tendon-lengthening operation on the internal recti in convergent strabismus, either alone or associated with an advancement of the external recti.

Dr. C. Shepherd and Dr. E. Temple Smith preferred partial tenotomy or tendon-lengthening, where a sufficient result could thus be obtained.

Dr. Guy Antill Pockley also strongly advocated this. He stated that he visited Newington and Lidcombe Asylums regularly, where one saw a great number of the failures. He had been struck by the very large number of cases he encountered with divergent eyes and retracted caruncles, as a result of tenotomy of internal recti. The numbers of these cases performed by many of the best ophthalmic surgeons in the State which ended up unsatisfactorily, had so impressed him that he had made it his practice to secure the result by the less easy operation of tendon-lengthening when possible.

Dr. R. H. Jones stated that his practice was to do a complete tenotomy with care, after exposing the tendon through a conjunctival incision. He thought that many of the catastrophes described by the previous speaker were probably due to doing the more old-fashioned, less accurate, subconjunctival tenotomy after exposing the tendon.

Dr. A. Wallace Welhen has resigned his appointment as Honorary Ophthalmic Surgeon to the South Sydney Hospital, New South Wales.

Abstracts from Current Medical Literature.

OPHTHALMOLOGY.

(9) Vascular Disease and Prognosis.

Omitting cases of true albuminuric retinitis, out of 159 patients with retinal vascular disease P. H. Adams has succeeded in tracing 124 (*British Journ. Ophthalmology*, March, 1917). Of the total, 63 were males and 96 females. In the first group (patients under 50 years of age) there were 26, and a remarkable difference in the length of life was found, the difference being due to the presence of albumin in the urine. Of those with albumin present seven died after intervals from four months to five years and one was alive after six years. Of those with no albumin six were living from four to 28 years, and one died after 16 years. In the second group (patients between 50 and 59) there were 47. The difference in prognosis between those with and without albumin is not so marked as in the younger group. Of those with albumin, many lived for a considerable time—one 13 years, another 9 years. Of the patients without albumin some died in from two to twelve years, many of the rest having survived from 1½ to 16 years. There were 54 in the third group (patients between 60 and 69). Those with albumin compared unfavourably with those without. Some of the latter were still alive 10 and 16 years after. In the fourth group, between 70 and 80, there were 26 patients. Some lived two, five, eight or ten years. Finally there were five patients over 80 years. Four of these lived from three to six years. The eyes were not damaged by ordinary use.

(10) Ocular Anaphylaxis.

Modifying the technique of previous observers, Allan C. Wood reports the results of experiments to ascertain if anaphylactic phenomena could be elicited by antigen carried to the eye by the blood stream in animals previously sensitized by intra-peritoneal injection (*Archives Ophthal.*, November, 1916, January, 1917). In order to perfuse the eyes successfully, it was found necessary to perfuse the entire head. (1) Perfusion of normal dogs with defibrinated blood for four to six hours caused no change in the eyes. (2) Perfusion of normal dogs with defibrinated normal blood, to which antigen, in the form of horse serum and uveal extract had been added, also produced no change in the eyes. (3) The dogs were now sensitized from three to five weeks by intra-peritoneal injections of specific antigen, horse serum and uveal extract. These dogs were then perfused, some with horse serum as antigen, others with cow's uveal extract as antigen. There were found marked contraction of the pupils, conjunctival and pericorneal injection, and small extravasations of blood in the fundus.

These are definite anaphylactic reactions.

The anaphylactic theory of sympathetic ophthalmia. In 1910 Elsching enunciated the anaphylactic theory of the origin of sympathetic ophthalmia. He believed that disintegrating uvea in the exciting eye was reabsorbed as antigen, and led to hypersensitiveness of the animal, and especially of the uvea of the other eye. The present author set out to determine: (1) The antigenic properties of homologous uvea-organ specificity. (2) The ability of one eye to react to perfusion in animals previously sensitized by intra-ocular injections of the other eye. (3) What constituent of the uvea was responsible. (1) Dogs were sensitized for two weeks by intra-peritoneal injection of dog's uveal emulsion, and were then perfused with defibrinated blood of normal dogs, to which dog's uveal emulsion had been added. Result: contraction of pupils, pericorneal injection and hæmorrhages throughout the fundus. He held that this proves that the absorption of homologous uvea has the property of sensitizing animals of the same species and of producing an ocular reaction upon subsequent perfusion. (2) Dogs were sensitized with intra-peritoneal injections of cow's uveal emulsion. Later perfusion was carried out with dog's uveal emulsion. Result: intra-ocular hæmorrhages. (3) Dogs sensitized with dog's uvea were perfused with dog's liver and kidney extracts. Result: negative. These two experiments are regarded as showing that even heterologous uvea produces a reaction, and that uveal tissue is essential. In experiments IV. and VI. one eye was sensitized by intra-ocular injection of cow's uveal emulsion, and later the other eye was perfused. While normal blood was used for perfusion, the result was negative, but when cow's uvea was added the typical reaction was obtained. The conditions of the experiment simulate closely those under which sympathetic ophthalmia occurs clinically. Experiments with uveal pigments were found to be difficult and inconclusive. Further work is being carried on.

(11) Intracapsular Extraction of Cataract.

Under the two heading "best vision" and "least risk," Arnold Knapp discusses the present status of intracapsular extraction of cataract (*Archives Ophthal.*, January, 1917). On the grounds of best vision, though the statistics are still meagre, the intracapsular extraction seems to have the best of the argument, whereas under the heading "least risk to the eye" it compares unfavourably with other methods. In the capsulotomy operation in careful hands vitreous loss is practically negligible; in the intracapsular it is anything from 5% to 40%. Eight American ophthalmologists who had studied with Smith wrote to the author giving their views. Two do not practice it at all; one performs it in 50% of cases and five in all cases with certain provisions. The author asks: "Are we justified for the purpose of obtain-

ing better vision in some additional cases to increase the number of poor results and failures?" He thinks not.

(12) Cilia in the Anterior Chamber.

H. Z. Begle makes a few remarks on the subject of eyelashes in the anterior chamber, the result of perforating injuries or very rarely of operations (*Archives Ophthal.*, January, 1917). They are often difficult to detect, and also difficult to remove. Their presence may be tolerated for a time, but ultimately they cause recurrent irritation, plastic inflammation, or epithelial tumours or cysts. He reports three cases: (1) A man, 19 years old, cutting a brass rod with an axe, got a piece of brass in the right eye. From the inner lips of the corneal wound a single full-length cilium extended horizontally in the anterior chamber, with the point free. There was no severe reaction, but five weeks later the wound near the base of the cilium showed signs of irritation. Removal of the cilium was advised, but the patient has not yet consented. (2) A man of 32 years was struck in the left eye by a piece of brass, and the cornea wounded. The anterior chamber contained four eyelashes. The lens became cataractous, and on the tenth day an attempt was made to wash it out. Two cilia were washed out with the lens matter, one was removed with an iris forceps, but the fourth could not be located. It was found a few days later in the anterior chamber, and ten months later the cornea was incised by a keratome and the cilium escaped with the aqueous fluid. (3) A man of 29 years was struck in the left eye while chipping a fire brick. No break in the continuity of conjunctiva, cornea or sclera could be made out, but an eyelash was seen embedded in the temporal side of the cornea. An attempt to remove it failed. Enucleation was advised but refused.

(13) Keratectomy.

Camillo Foroni has performed keratectomy during the last four years in 200 cases of corneal abscesses (hypopyonkeratitis) (*Archives Ophthal.*, January, 1917). An incision is made with a knife in the healthy cornea all round the diseased part, dividing only the superficial layers. The inner margin of the wound is then grasped with forceps or hook "and the entire cornea within the incision is carefully dissected off. Care must be taken not to penetrate the anterior chamber or to expose Descemet's membrane." The wound is then scraped carefully and irrigated with 1 in 1,000 solution of bichloride of mercury. The objection to the use of the cautery is the addition of dead tissue, which prevents the action of remedies. Paracentesis of the anterior chamber by the cautery is advocated, as the iris is not invaded.

LARYNGOLOGY AND OTOTOLOGY.

(14) Naso-pharyngeal Hæmorrhage.

In discussing preventive measures in naso-pharyngeal hæmorrhage J. Wein-

stein draws attention to certain anatomical considerations involved (*Laryngoscope*, March, 1917). The blood vessels are said to lie closer to the tonsils in adults than in children, and to lie closer to the lateral pharyngeal wall on that side from which the head is turned away than on the opposite side. The internal carotid is $\frac{1}{2}$ to 1 cm. distant from the tonsil, the external carotid 2 cm. The facial, lingual, ascending palatine and sometimes the ascending pharyngeal arteries, as well as the submucous peripharyngeal plexus of veins are also in intimate relation with the pharyngeal wall. The author quotes J. L. Davis to the effect that the entire tonsillar blood supply comes from one artery, formed by the anastomosis of the ascending palatine branch of the facial with the descending branch of the internal maxillary. The artery thus formed enters the fossa at its superior extremity, passes downward through the capsule for about 1.5 cm., and then penetrates the capsule to reach the tonsil parenchyma. In 95% of the cases, at least, the tonsillar branch of the facial, the branch from the *dorsalis linguae*, and the branch from the ascending pharyngeal supply only the surrounding structures. Davis therefore, after enucleation, ligates the artery in the upper part of the tonsillar fossa in adults, and even in children when bleeding is profuse and continuous. The author advises the following hæmostatic measures for profuse hæmorrhage in the order as stated. (1) Mikulicz's forceps, (2) sewing together palatal arches, (3) compression of the common carotid, (4) ligation of the common carotid or its branches. In connexion with therapeutic measures for decreasing the coagulation time of blood it is observed that moderately severe hæmorrhage (13% of the circulating blood) decreases the clotting time. Adrenalin, in small doses, intravenously, decreases the coagulation time one-half or one-third, and this effect is not associated with any corresponding effect on the blood pressure. Pain and strong emotions, by stimulating the adrenals, shorten the clotting time. Stimulation of afferent nerves, like the sciatic and crural, or major operations under light anaesthesia markedly shorten the coagulation time. Ether anaesthesia, by its action on the adrenals, has also this effect, but chloroform and chloral hydrate have little influence. Emetine, the active principle of ipecacuanha, in a 0.03 gm. injection 15 minutes before operation, reduces the coagulation time by one-third; pituitrin has a similar effect. *Coagulen ciba*, an extract of blood platelets, seems to have an instantaneous effect in shortening the time of clotting. Thromboplastin (tissue juice), prepared from the liver and brain of cattle, coagulose, from precipitated normal blood, and normal horse serum have all given good results.

(15) Frontal Sinus Suppuration.

The operations of Ogston-Luc, Kunt, Jansen, Riedel, and Killian for frontal sinus suppuration are reviewed by H. A. Lotherp, (*Laryngoscope*, January, 1917).

He considers that they all produce unnecessary deformity, often with a failure to achieve the requisite drainage and restoration of the integrity of the sinus lining, or obliteration of the sinus itself. He holds that probing and irrigation of an affected sinus are of little value, but removal of the anterior end of the middle turbinal, and breaking down neighbouring thin-walled cells may, by giving a free drainage, bring about a cure. If this fails, and a more radical procedure is called for, he recommends a single small external opening, combined with intranasal manipulations, the cutting instrument being at all times in view. The essential feature of this technique is the removal of the entire nasal floor of both sinuses, laterally from lachrymal to lachrymal bone, and, antero-posteriorly, from the thinned bone at the region of the naso-frontal suture back to the posterior wall of the sinus near the *crista galli*, together with the interfrontal and underlying internal septa. There should be no exploration behind or internal to the *ostium frontale* on account of the posterior wall and cribiform plate. Around the ostium are thin-walled anterior ethmoid cells, easily broken through with a curette. In front of these cells and also in the median line, there is a dense mass of bone formed by the upper thickened ends of the nasal bones, and the nasal processes of the maxillæ, also the junctioning portions of the interfrontal septum, median plate of the ethmoid and frontal spine. This mass must be removed nearly down to the periosteum by rasps or burrs, with curved shanks, under direct observation through an oval opening $\frac{3}{4}$ inch long in the facial wall of the sinus, mesial to the supra-orbital foramen. Finally, the interfrontal septum, a considerable portion of the ethmoid plate below the sinus, and as much of the ethmoid mass as is deemed advisable are removed in order, and the external wound closed. A sterile gauze dressing is placed in the nose for 24 hours, but irrigation is not recommended for several days. Anterior and lateral X-ray views, to outline the sinus, are advised prior to operation.

(16) Orthopædic Treatment of Laryngeal Stenosis.

The gradual reduction of the size of a slot in a rubber cork in a tracheotomy cannula, the latter being small relative to the size of the trachea, until a solid cork can be worn, is held by Chevalier Jackson (*Journ. of Laryng., Rhin. and Otolaryngology*, February, 1917) to be the best test of the ability to breathe through the mouth, as well as the best means of establishing confidence in the oral breathing route in laryngeal stenosis. The final test is the ability to sleep quietly without indrawing at the guttural fossa, at the epigastrium, or around the clavicles. The cannula can then be permanently removed. He stresses the "orthopædic" action of this method, i.e., in cases with more or less

fixation of the crico-arytenoid joint the enforced effect necessary to inspire through the larynx forces the maximum possible movement on the larynx. The muscles atrophied from prolonged idleness are stimulated to develop, and the stiffened joints are on the more or less cicatricially-margined glottis tends in time to enlarge that glottis. If treated early the effect in purely paralytic conditions is often marked. The best results are obtained in children, due, probably, to the contributory aid of growth, and in cases which have not been subjected to too much ill-advised surgery, by thyrotoxy, laryngostomy, etc. Success depends largely on the amount of intrinsic muscular tissue remaining.

(17) Choanal Polypus.

Calomel vapour in the treatment of constitutional and local conditions is eulogized by Edward J. Brown (*Laryngoscope*, March, 1917). The apparatus he employs consists of a 7.5 cm. section of iron tubing of 1.25 cm. bore, to admit a small phial for the calomel, a reducer connecting this with a 15 cm. section of 0.6 cm. tubing, and, for inhalations, the latter is connected by a short rubber tube to a conical nasal-tube of glass. A Bunsen burner is the source of heat. The author mentions Coffin's and Harmon Smith's advocacy of negative and positive pressure, alternately, in the treatment of nasal sinus diseases, the negative, obtained by inhaling strongly with the nose and mouth tightly closed, emptying the accessory chambers; the positive, by forcing oil nebula, loaded with either chemicals or lactic acid, into the vacuumized sinuses. The author substitutes hot vapours of calomel for the nebula, and reports gratifying results. He considers that efficient doses may be administered in 10 to 15 minutes' sittings, and advises the admission of a minimum of air with the vapour to avoid irritation. He varies the treatment, at times, by insufflations of dry calomel powder, or combinations of calomel and boric acid or kaolin. He instances several remarkable successes of the vapour in cases of intractable blepharitis, chronic tubercular sinus and mucous colitis.

(18) Repair of Tympanic Membrane.

The Okuneff trichloracetic method has, in the hands of A. M. Dunlap, proved most effective in closing tympanic perforations (*Laryngoscope*, February, 1917). A 10% solution of cocaine is first applied to the membrane for a few minutes, wiped away, and the edges of the perforation touched with a saturated solution of trichloracetic acid. This procedure is repeated at intervals of three to five days until the perforation is closed. Thirty to forty applications may be required. A weaker solution of the acid and longer intervals between the applications may be advisable in the later stages. Neither the size of the perforation nor the age of the patient has influenced the final result.

British Medical Association News.**ANNUAL MEETING.**

The Annual Meeting of the South Australian Branch was held at the House of the Branch, Hindmarsh Square, Adelaide, on June 28, 1917, Dr. J. C. Verco, the President, in the chair.

Report of Council.

The Annual Report of the Council for the year ending June 30, 1917, and the Financial Statement and Balance Sheet were presented and adopted.

Annual Report of the Council for Year ended 30th June, 1917.

The Council has the honour to submit the following report of the work of the Branch for the year ended June 30, 1917.

Membership.—The Branch now consists of 251 members. Of these, five were elected during the year.

The Council regrets to record the deaths of the following members:—

Dr. C. E. Todd, of Victoria Square;
Dr. C. C. McDonald, of Mount Gambier;
Dr. L. L. Seabrook, of Broken Hill; also
Captain N. C. Shierlaw
Captain R. B. Lucas
Captain C. B. Burden } While on active service.

Meetings.—The annual meeting was held in the evening of last June, as there was no dinner. There was an exhibition of Australian products, largely of local manufacture, in which members manifested much interest.

Nine ordinary meetings were held, the average attendance being 28 members.

At the ordinary meetings and clinical evenings 17 papers were read, and 17 living exhibits and many pathological specimens were shown.

The Council has met 12 times during the year, and much work has been accomplished.

Statement re		Library Fund.	
	£ s. d.		£ s. d.
To Balance, December 31, 1915	64 12 7	By University Library.. .. .	50 0 0
" Interest	2 19 11	" Balance	66 14 0
" To Subscriptions, 1916 (82)—			
Full Members.. .. .	£43 1 0		
Arrears—11¼ Members	6 0 6		
	49 1 6		
	£116 14 0		£116 14 0

To Balance, £66 14 0

Difference between amount received for subscriptions and amount paid to University, 18/6.

Adjustment to be made at end of this year.

BRITISH MEDICAL ASSOCIATION, SOUTH AUSTRALIAN BRANCH.**Revenue Account for Year Ended 31st December, 1916.**

£ s. d.		£ s. d.	
To Sundry Expenses — Printing, Stationery, Postage, etc.	20 15 6	By Balance as at December 31, 1915	570 1 9
" Clerical Assistance	20 0 0	" Subscriptions and Arrears.. .. .	613 1 3
" Grant to University Library	50 0 0	" Less Amounts Repaid—	
" British Medical Journal	256 10 7	Medical Benevo-	
" The Medical Journal of Australia..	194 9 9	lent Fund	£8 10 0
" Depreciation Written Off Plant, Furniture, etc.	7 6 0	Medical Defence	
		Association	6 14 0
			15 4 0
" Balance as at December 31, 1916	666 17 5		597 17 3
		" Interest on Treasury Bills and Bank Ac-	
		counts	15 14 9
		" Subscriptions Received in Advance	22 5 6
		" Received from Military for Clerical Assist-	
		ance	10 0 0
			1,215 19 3
	£1,215 19 3		£1,215 19 3

Balance-Sheet as at 31st December, 1916.

LIABILITIES.		ASSETS.	
£ s. d.	£ s. d.		£ s. d.
To Sundry Creditors—		By Plant—Duplicator, Bookcases, Cabinet.. ..	138 15 6
Capitation Grant to Federal		" Sundry Debtor—Interest Account	4 0 0
Committee for 1915	5 18 0	" Treasury Bills.. .. .	100 0 0
The Medical Journal of Australia	16 0 0	" Bank Balances—	
		National Bank	£128 14 3
" Balance as at December 31, 1916	666 17 5	Savings Bank.. .. .	218 12 3
		Commonwealth Bank	31 0 11
		" Savings Bank—Library Fund	67 12 6
			445 19 11
	£688 15 5		£688 15 5

Audited and found correct,
June 14, 1917.

H. HIGHAM WIGG.

Library.—The usual grant of £50 has been paid to the University, and many periodicals are being taken for the use of members.

Federal Committee.—The Federal Committee met in Sydney in April this year, and a considerable number of subjects were discussed, the question of military service and lodge practice being among the most important. Dr. F. S. Hone and the Acting Hon. Secretary, in place of Dr. W. T. Hayward, represented the Branch. Dr. W. T. Hayward was re-elected Chairman of the Committee.

The War.—Many members are still on active service, and the Council congratulate those members who have been promoted and have received military and civil honours.

During the mobilization of October, 1916, the profession as a whole did excellent service, and it is satisfactory to note that practically the whole profession in this State is in the Australian Army Medical Corps.

The Council has decided that, in order to safeguard the interests of medical men on military duty both at home and abroad, that a committee, having a similar Constitution to the Fourth District Medical Committee, should meet and assist men returning from active service, both those resuming their practices and those desiring to start in practice. It is felt that this will enable many difficulties to be avoided which could not be obviated by direct communication between individuals.

Political.—Attempts are being made to obtain a new Medical Act for this State.

Metric System in Prescribing.—The Metric System has been introduced into the Adelaide Hospital, and a new Pharmacopoeia is in preparation at the Children's Hospital.

JOS. C. VESCO, President.

A. CAMPBELL MAGAREY, Acting. Hon. Sec.

June 14, 1917.

Election of Officers.

The following members were elected to the Council for the ensuing year:—

President: Dr. J. C. VESCO.

Vice-Presidents: Dr. H. H. E. Russell and Dr. R. H. Pulleine.

Honorary Secretary: Dr. H. S. Newland.

Honorary Treasurer: Dr. W. A. VESCO.

Honorary Auditor: Dr. H. H. Wigg.

Members of the Federal Committee: Dr. W. T. Hayward and Dr. F. S. Hone.

Members of Council: Dr. H. Gilbert, Dr. B. Smeaton and Dr. A. F. Stokes (elected); Dr. J. E. Good, Dr. W. J. Gregorson and Dr. Hampden Carr (elected 1916).

Members of the Library Committee: Dr. F. S. Hone, Dr. A. A. Lendon, Dr. A. C. Magarey, Dr. H. Swift.

Representative of "The Medical Journal of Australia": Dr. A. C. Magarey.

Dr. J. C. VESCO, the President, read an address, the text of which will be found on page 21 of this issue.

SCIENTIFIC.

A meeting of the Western Australian Branch was held at the Perth Hospital on May 16, 1917, Dr. J. K. Couch, the President, in the chair.

Dr. G. W. Barker showed a specimen of a brain from a patient who had been sent in from the Out-Patients' Department by Dr. F. A. Hadley. The operation of trephining had been performed, but the patient had died. Post-mortem a tumour of the cerebellum had been discovered. The tumour was probably a glioma.

Dr. Barker also showed for Dr. T. Ambrose a specimen of a stomach that had been excised for malignant disease. The patient was apparently well, and was earning £3 10s. per week in the North-West.

Dr. Barker showed, in the last place, a brain from a female, aged 29 years. The patient was quite conscious when admitted into the hospital. The post-mortem examination had revealed marked atrophy of the right kidney, and compensatory hypertrophy of the left kidney, with nephritis. The left ventricle of the heart was hypertrophied. There was a hæmorrhage at the base of the brain in the circle of Willis.

Dr. H. K. Couch exhibited a specimen of ectopic pregnancy. Dr. J. J. Holland gave some details concerning the history of the case.

In the discussion on these specimens Dr. Holland stated that he had attended the patient who died of cerebral hæmorrhage in two confinements, six and four years previously. The labours had not presented any difficulty, and he had not seen any signs or symptoms of disease in the patient.

Dr. J. K. Couch referred to the case of a man under the care of Dr. Byrom Bramwell twenty-five years before. Dr. Bramwell had made the diagnosis of cerebellar tumour. The patient had died recently, and at the post-mortem examination the diagnosis made so many years before, was confirmed.

Dr. W. H. Nelson reported a case of amoebic dysentery in a Western Australian. He gave an account of the symptoms, which were quite typical. The patient had served in the Boer War. There were no signs of tuberculosis. Dr. Shearman had examined the stools, and although active amoebæ were found, he regarded the condition as a bacillary dysentery. The patient was sent to hospital and placed under rigorous treatment. Considerable improvement followed. After a time solid motions were passed. On examination, the cysts of *amoeba histolytica* were demonstrated. Dr. Nelson held that the administration of emetine had been largely responsible for the improvement in his condition. He warned members against the risk of numerous cases of this kind occurring when the soldiers now on active service returned. He read Dr. Shearman's report, which included a description of the life-history of the *amoeba histolytica* and its action on the human host.

Dr. S. J. Cantor detailed his experience of amoebic dysentery in Egypt. He laid stress on the value of emetine in the treatment of this condition.

Dr. R. C. E. Atkinson dealt with the infectivity of *amoeba histolytica*.

Dr. W. Trethowan stated that in Egypt large doses of ipecacuanha had been considered essential, either as well as emetine or in its stead, in the treatment of amoebic dysentery.

Dr. W. E. Blackall described a similar case, which was under his care at the time of speaking. The patient had improved rapidly at first under emetine treatment, but in a relapse the emetine had failed entirely to alleviate the symptoms.

Dr. H. Gill asked Dr. Trethowan if emetine had been found to have a damaging effect on the causal organisms in the bacillary types of dysentery. Dr. Trethowan replied that, though it had no apparent ill effect, it certainly had no good effect.

Dr. G. W. Barker read the notes of a case of anthrax which had occurred in the State. The patient had been admitted to the Perth Hospital. Dr. Barker described the history of the case and the appearances of the lesion. The ulcer had been excised, and the wound cauterized. In his report, Dr. Shearman had given an account of the results following the inoculation of a guinea-pig with the bacilli derived from the ulcer.

Dr. M. K. Moss referred to a few cases of anthrax which he had had under treatment, and Dr. Trethowan recalled a case which had occurred in a man working in a tannery in Duke Street.

Dr. R. C. E. Atkinson dealt with the public health point of view of the case. He stated that many persons had become infected from shaving brushes.

MEDICO-POLITICAL.

A meeting of the Western Australian Branch was held at the Perth Hospital on May 16, 1917, Dr. J. K. Couch, the President, in the chair.

King Edward's Hospital for Women.

Dr. M. K. Moss moved that the Western Australian Branch of the British Medical Association protest against the type of patients being admitted to the King Edward Hospital. He maintained that the patients admitted should be of the poorer class, who were unable to pay for treatment outside.

The motion was seconded by Dr. W. H. Nelson.

After Drs. Robertson, Merryweather, Officer and Clemont had spoken on the subject, Dr. R. C. E. Atkinson stated that he had been on the look-out for abuses of this nature. He had not heard of any. If the abuses could be definitely proved, he was prepared to confer with the Minister with a view to having a wage-limit fixed.

An amendment was proposed by Dr. R. C. Merryweather and second by Dr. H. Gill, that the discussion be postponed for 12 months. The amendment was carried.

Anatomist.

Dr. J. J. Holland asked if any members would be interested in dissection. He proposed that the Council be requested to take steps to approach the Government for the purpose of having a licensed anatomist appointed for the State. Dr. H. J. Gray seconded the motion, which was carried unanimously.

The President.

Dr. J. K. Couch, the President, announced that he expected to leave the State almost immediately on active service. He thanked the members for the courtesy they had extended to him during his short occupancy of the chair, and welcomed his successor, Dr. R. C. E. Atkinson.

Service with the A.I.F.

A discussion took place on the subject of the supply of medical men for military service with the forces abroad. Dr. Robertson, who opened the discussion, asked for information in regard to what was being done. Drs. Tretowan, Moss, Cantor and Couch spoke. Dr. D. D. Paton moved that the discussion be adjourned until the Council had a reply from the Defence Department. The motion was seconded by Dr. Gray and carried.

Harold William Cuthbert, M.B., 1917, Univ. Sydney, of "Burnleigh," Carabella Street, Kirribilli, Sydney, has been nominated for election as a member of the New South Wales Branch.

Naval and Military.

The 318th and 319th lists of casualties were issued on July 6, 1917, and together contain the names of 2,058 officers and men. The 320th list, which was issued on July 9, 1917, contains 1,224. Only one medical officer is mentioned in these three lists, namely, Captain Sydney Vere Appleyard, who is reported to be seriously ill.

It has been reported that Major H. V. P. Conrick has been awarded the Distinguished Service Order. Captain Randal Vivian McDonnell, R.A.M.C., has been awarded the Military Cross, and Captain Arthur Wilmot Raymond, who is also a Sydney graduate, has obtained the same distinction.

We learn that the Military Medal has been awarded posthumously to Private Harold Oliver, son of Dr. W. R. Oliver, of Chatswood.

In *The Commonwealth of Australia Gazette*, No. 103, of June 29, 1917, the Minister for Defence publishes extracts from the various London Gazettes dealing with decorations and distinctions conferred on members of the Australian Imperial Force. In the following we reproduce the several entries referring to members of the Australian Army Medical Corps.

To be additional members of the Third Class, or Companions of the Most Distinguished Order of St. Michael and St. George:—

Lieutenant-Colonel (now Colonel) Alfred Sutton, A.M.C.

Awarded the Distinguished Service Order—

Major (now Lieutenant-Colonel) Joseph Esple Dods, M.C., A.M.C.

Major Henry Kenneth Fry, A.M.C.

Lieutenant-Colonel (temporary Colonel) (now Colonel) Charles Henry William Hardy, V.D., A.M.C.

Major (now Lieutenant-Colonel) Alexander Hammett Marks, A.M.C.

Lieutenant-Colonel John Hare Phipps, A.M.C.

Lieutenant-Colonel Thomas Gordon Ross, A.M.C.

Lieutenant-Colonel Charles Gordon Shaw, A.M.C.

Lieutenant-Colonel John Basil St. Vincent Welch, A.M.C.

Awarded the Military Cross—

Captain (now Major) James Bentley, A.M.C.

Captain John Bright Birch, A.M.C.

Captain (now temporary Major) Arthur Edmund Colvin, A.M.C.

Captain Eric Mortley Fisher, A.M.C.

Captain John Thomas Jones, A.M.C.

Captain James Beverley Metcalfe, A.M.C.

The following dispatch has been received by the Secretary of State for War from General Sir Douglas Haig, G.C.B., Commander-in-Chief of the British Armies in France:—

General Headquarters,

13th November, 1916.

Sir,—

I have the honour to submit a list of names of those officers, ladies, non-commissioned officers and men, serving, or who have served, under my command, whose distinguished and gallant services and devotion to duty I consider deserving of special mention.

I have the honour to be, Sir,

Your obedient servant,

D. HAIG, General,

Commander-in-Chief of the British Armies in France.

Australian Imperial Force.

Infantry.

(Among many names)—

Winn, Captain R. C., A.M.C.

Brettingham-Moore, Captain H. M.

Army Medical Corps.

Staff.

Barber, Colonel G. W.

Butler, Major (now Lieutenant-Colonel) A. G., D.S.O.

Dods, Major (now Lieutenant-Colonel) J. E., M.C.

Fry, Major H. K.

Hardy, Lieutenant-Colonel (Temporary Colonel)

(now Colonel) C. H. W., V.D.

Marks, Major (now Lieutenant-Colonel) A. H.

Sturdee, Lieutenant-Colonel (Temporary Colonel)

(now Colonel) A. H., C.M.G., V.D.

Sutton, Colonel A.

Anderson, Major J. H.

Bailey, Captain G. B. (deceased).

Butler, Lieutenant-Colonel H. N.

Byrne, Major G. C.

Catford, Captain H. R.

Embleton, Captain (now Major) D. M.

Hearne, Lieutenant-Colonel (now Temporary

Colonel) W. W.

Henderson, Captain R. L.

Horn, Lieutenant-Colonel A.

Huxtable, Lieutenant-Colonel (now Temporary

Colonel) R. B.

Jeffries, Major L. W.

Lewers, Major H. B.

McGregor, Major R. S.

McLennan, Captain S.

Mattei, Major C.

Meikle, Lieutenant-Colonel (now Colonel) A. J.

Phipps, Lieutenant-Colonel J. H.

Plant, Captain H. F. H. (since deceased).

Powell, Captain A. H.

Ross, Lieutenant-Colonel T. G.

Savage, Captain (now Major) V. W.

Shaw, Lieutenant-Colonel C. G.

Smith, Captain A. C.

Wall, Captain F. L.

Welch, Major (now Lieutenant-Colonel) J. B. St. V.

Woollard, Captain (temporary Major) (now Major)

H. H.

In *The Commonwealth of Australia Gazette*, No. 107, of July 5, 1917, the following record of appointments, etc., is published:—
Army Medical Corps.

To be Lieutenant-Colonel (with pay of Major)—

Honorary Lieutenant-Colonel L. W. Bickle, Retired List. Dated 2nd November, 1915.

(This cancels the notification respecting this Officer which appeared in Executive Minute No. 1049 of 1917, promulgated in *Commonwealth of Australia Gazette*, No. 157, of 16th December, 1915.)

To be Captains—

Captain C. G. Thompson, Australian Army Medical Corps. Dated 18th June, 1917.

Honorary Captain W. J. Binns, Australian Army Medical Corps Reserve. Dated 22nd May, 1917.

Honorary Captain A. M. Purves, Australian Army Medical Corps Reserve. Dated 24th May, 1917.

Honorary Captain W. J. Trehwella, Australian Army Medical Corps Reserve. Dated 2nd April, 1916.

Lieutenant A. J. Bothamley, 56th Infantry (The Yarra Borderers). Dated 13th June, 1917.

Cyril Charles Minty. Dated 28th November, 1915.

(This cancels the notification respecting the date of appointment of this Officer which appeared in Executive Minute No. 99 of 1917, promulgated in *Commonwealth of Australia Gazette*, No. 17, of 3rd February, 1916.)

Alexander Allison Lang. Dated 21st May, 1917.

William Frederick Pattinson. Dated 24th May, 1917.

Thomas Simpson Campbell. Dated 6th June, 1917.

Phillip Leslie Daniel. Dated 22nd May, 1917.

John Patrick Farrell. Dated 14th June, 1917.

Termination of Appointments.

The appointments of the undermentioned officers are terminated from dates stated opposite names:—

Colonel A. H. Sturdee, C.M.G., V.D.—27th April, 1917.

Lieutenant-Colonel J. A. Newell—26th May, 1917.

Major R. E. Shuter—23rd June, 1917.

Captain D. G. M. Teague—26th May, 1917.

Captain C. R. Palmer—29th May, 1917.

Captain H. F. Alsop—29th May, 1917.

Captain E. Russell—23rd May, 1917.

Captain S. P. Lyttle—30th May, 1917.

Captain R. M. Allan—10th May, 1917.

Captain H. E. A. Jackson—12th June, 1916.

(This cancels the notification respecting this Officer which appeared in Executive Minute No. 589 of 1916, promulgated in *Commonwealth of Australia Gazette*, No. 83, of 13th July, 1916.)

The temporary rank of Major granted to Captain H. S. McLelland be terminated. Dated 30th April, 1917.

To be Majors—

Captain J. B. Metcalfe, M.C., No. 14 Field Ambulance.

Captain C. J. Wiley, No. 1 Australian Dermatological Hospital.

Captain W. Vickers, No. 9 Field Ambulance.

Captain A. T. Dunlop, No. 4 Field Ambulance.

Captain W. F. Matthews, No. 3 Australian General Hospital.

Captain L. R. Cook, No. 2 Field Ambulance.

Captain (temporary Major) J. A. Smeal, No. 1 Australian Auxiliary Hospital.

Captain F. D. H. B. Lawton, No. 3 Australian General Hospital.

Captain E. R. Corder, Attached 51st British General Hospital.

Captain A. P. Drummond, No. 1 Field Ambulance.

Captain W. A. Halles, Regimental Medical Officer, 4th Field Artillery Brigade.

Captain J. C. Mayo, No. 2 Field Ambulance.

Captain J. R. Muirhead, Regimental Medical Officer, 2nd Divisional Engineers.

Captain M. Yuille, No. 3 Light Horse Field Ambulance.

Captain J. C. Wells, Regimental Medical Officer, 1st Light Horse Regiment.

Captain T. C. C. Evans, No. 13 Field Ambulance.

Captain F. T. Beamish, Regimental Medical Officer, 1st Battalion.

Captain T. F. Brown, D.S.O., No. 1 Australian Dermatological Hospital.

Captain M. V. Southey, 4th Divisional Base Depôt.

Captain J. D. Norris, No. 2 Command Depôt.

Captain P. A. Mapleston, Regimental Medical Officer, 25th Field Artillery Brigade.

Captain W. J. Stack, No. 1 Field Ambulance,

Captain G. H. Vernon, M.C., Regimental Medical Officer, 11th Light Horse Regiment.

Captain J. Sprent, M.C., No. 13 Field Ambulance.

Captain W. J. W. Close, Regimental Medical Officer, 58th Battalion.

Dated 29th January, 1917.

To be Temporary Major—

Captain T. L. Anderson, No. 3 Australian General Hospital. Dated 29th January, 1917.

Captain C. S. Browne, No. 1 Australian General Hospital, is granted the temporary rank of Major whilst performing the duties of Registrar. Dated 29th January, 1917.

Australian Military Forces.

1st Military District.

Australian Army Medical Corps Reserve—

Thomas Wilson to be Honorary Captain. Dated 1st May, 1917.

2nd Military District.

Australian Army Medical Corps—

The temporary rank of Major granted to Captain H. R. Sear is terminated. Dated 5th June, 1917.

Australian Army Medical Corps Reserve—

Alfred Paul to be Honorary Captain. Dated 28th February, 1916.

Adam John Newton to be Honorary Captain. Dated 28th May, 1917.

3rd Military District.

Australian Army Medical Corps Reserve—

George John Henry Atkinson, Frank Tipping, and George Leonard Lillies to be Honorary Captains. Dated 1st June, 1917.

Honorary Captain D. G. Robertson is transferred to Australian Army Medical Corps Reserve, 5th Military District, with seniority as from date of transfer. Dated 1st May, 1917.

4th Military District.

Australian Army Medical Corps Reserve—

John James O'Grady to be Honorary Captain. Dated 21st May, 1917.

5th Military District.

Australian Army Medical Corps—

Captain (Honorary Lieutenant-Colonel) J. E. F. Stewart is transferred from Unattached List, with seniority as from 2nd June, 1908. Dated 1st May, 1917.

Australian Army Medical Corps Reserve—

Honorary Captain D. G. Robertson is transferred from Australian Army Medical Corps Reserve, 3rd Military District, with seniority as from date of transfer. Dated 1st May, 1917.

Australian Army Medical Corps—

Majors (temporarily) T. F. W. Hall and D. A. Cossar to be Staff Officers to Director-General, Australian Army Medical Services (temporarily), with pay as for rank of Major, at rate prescribed by Financial and Allowance Regulation 340, when actually employed on military duty. Dated 1st July, 1917.

Public Health.

NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending June 30, 1917:—

	Metropolitan District.		Hunter River District.		East of State.		Total.
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.	Cs. Dths.
Enteric Fever ..	7	0	1	0	5	1	13 1
Scarlatina ..	28	0	1	0	13	1	42 1
Diphtheria ..	56	1	10	0	50	1	116 2
*Pul. Tuberculosis	10	9	4	0	0	0	14 9

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

VICTORIA.

The following notifications have been received by the Board of Public Health, Victoria, during the week ending July 1, 1917:—

Disease.	Metro-politan.		Rest of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Diphtheria	71	3	39	3	110	6
Scarlatina	33	0	18	0	51	0
Enteric Fever	0	0	1	0	1	0
Pulmonary Tuberculosis	17	15	9	4	26	19
C'bro-Spinal Meningitis	2	—	0	—	2	—

QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending June 30, 1917:—

Disease.	No. of Cases.
Diphtheria	29
Scarlatina	7
Pulmonary Tuberculosis	5
Enteric Fever	3
Puerperal Fever	1
Erysipelas	5
Ankylostomiasis	3

SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, for the week ending June 23, 1917:—

Disease.	Adelaide.		Rest of State.		Totals.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Diphtheria	1	0	38	0	39	0
Pulmonary Tuberculosis	1	2	11	1	12	3
Scarlatina	2	0	4	0	6	0
Morbili	0	0	5	0	5	0
Pertussis	0	0	4	0	4	0
Enteric Fever	0	0	2	0	2	0
Erysipelas	0	0	1	0	1	0

WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the three weeks ending June 23, 1917:—

Disease.	Metro-politan.		Rest of State.		Totals.	
	Cases.	Cases.	Cases.	Cases.	Cases.	Cases.
Enteric Fever	4	1	—	—	5	—
Diphtheria	44	16	—	—	60	—
Pulmonary Tuberculosis	6	9	—	—	15	—
Erysipelas	4	2	—	—	6	—
Septicæmia	2	1	—	—	3	—
Ophthalmia	1	0	—	—	1	—
Cerebro-Spinal Meningitis	5	0	—	—	5	—

TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the week ending June 30, 1916:—

Disease.	Hobart.		Launceston.		Country.		Whole State.	
	Cases.	Cases.	Cases.	Cases.	Cases.	Cases.	Cases.	Cases.
Diphtheria	3	7	14	—	—	—	24	—
Enteric Fever	1	0	0	—	—	—	1	—
Pulmonary Tuberculosis	0	0	3	—	—	—	3	—

Obituary.

WILLIAM JAMES BARKAS.

The sudden death of William James Barkas, which we recorded in our issue of last week, has occasioned very widespread regret.

William James Barkas was born in 1848 in the north of England. He was the eldest son of the late Councillor T. P. Barkas, a well-known scientist of Newcastle-on-Tyne. He

received his medical education at Newcastle and Durham, and at the age of 20 obtained the diplomas of the membership of the Royal College of Surgeons of England and of the licentiate of the Royal College of Physicians, London. The first six years of his professional life was spent in England. A serious illness led him to seek health in sunny New South Wales. He sailed in the first steamer that accomplished the whole distance under her own steam. In 1875 he started practice at Bombala, in New South Wales, and later he spent some time at Warialda. In 1882 he moved to Paddington, and shortly after was appointed medical adviser to the State Children's Relief Department, a position which he filled with credit and honour for 35 years. He took a keen interest in the welfare of infants and children, and studied the various problems associated with this department of medicine. He was one of the founders of the Eastern Suburbs Medical Association, an Association affiliated with the New South Wales Branch of the British Medical Association. He filled the office of President, and served for many years as Honorary Treasurer. He relinquished the latter post one year ago.

Dr. James Hughes, writing of him, says that he was unostentatious, kindly and sincere, and that he was highly estimated by all during his long residence in the eastern suburbs. He was one of the pioneers in the organization of the medical profession in New South Wales, and was a member of that strenuous, earnest band to whom succeeding medical generations owe a debt of gratitude deeper than they realize.

Special Correspondence.

(By our Special Correspondent.)

CANADA LETTER.

The Ontario Medical Commission.

The sittings of the Medical Commission appointed by the Government of Ontario were resumed at the end of January, under the direction of Mr. Justice Hodgins. Representatives of the Nurses' Association of the province appeared before the Commission. The use of the terms "graduated," "certified," "trained," and "registered," as applied to nurses was discussed, and it was proposed that the exact use and meaning of such terms should be defined, and that nurses who had graduated from correspondence schools and had not received a diploma from any medical training school attached to a hospital should not be permitted to call themselves "registered" nurses. Representatives of the opticians of the province also appeared with the request that they be given professional standing, and be permitted to form an optometrical association, and appoint a board to examine and license opticians, who would supply glasses for the correction of defective vision, but would not attempt to give medical treatment for diseases of the eye. Objection to this was made by representatives of the Toronto Academy of Medicine on the ground that no man who had not been trained in medicine could examine the eye properly, and that opticians did not employ the same mechanical apparatus as that used by doctors, and, moreover, were not adequately trained to do refraction work.

The Feeble-minded in Ontario.

Although the province of Ontario is probably doing more already to provide for the care of the feeble-minded than any other province in the Dominion of Canada, the problem even in Ontario has been by no means solved. The importance of providing institutional care for those who are defective mentally has been brought home forcibly to all thinking people by the war, when so many young lives of promise are being laid down on the battlefield, and during the past two years an investigation into conditions existing in Ontario has been made by Dr. C. K. Clarke and Dr. C. M. Hincks, of the Psychiatric Clinic of the Toronto General Hospital. Some of the results of this investigation were given at a recent meeting of the Toronto Academy of Medicine, when it was stated that out of 1,445 examinations made, 55% of the feeble-minded were found to be habitual

criminals, 285 were habitual thieves, 120 were homicidal subjects, and 210 cases of absolute incorrigibility in children were found, of whom 53 were victims of immorality. The following suggestions were made by the Toronto Branch of the Ontario Association for the Care of the Feeble-minded, as a possible means of dealing with the situation, *viz.*, that industrial farms should be established, one for boys and one for girls; that a psychiatrist should be appointed, who would work in co-operation with the general inspector of schools to determine which pupils should be sent to the farms, and that a special grant for this purpose should be made by the provincial government. The matter was taken up at a meeting of the Toronto City Council, when it was decided that a request should be made to the Ontario Government for permission to issue debentures to the amount of one hundred and fifty thousand dollars for the purpose of establishing homes for the feeble-minded.

Correspondence.

THE SANATORIUM TREATMENT OF EARLY PHTHISIS.

Sir,—For many years past, in fact from the time the Queen Victoria Homes for Consumptives came into existence, the Board of Management have experienced considerable difficulty in obtaining a really suitable class of case for the work of the Homes.

Of late years, and especially since the opening of the Anti-Tuberculosis Dispensaries, this difficulty has become accentuated.

There are in reality two reasons why we experience difficulty in getting suitable cases for our Homes: the one is that those suffering in the early stages do not feel ill enough to give up work and income to enter a sanatorium, and the other is that they hope to be cured by domiciliary treatment without loss of either work or income.

Now it is true that a patient may be cured by domiciliary treatment, but it is certain that his chances of recovery are much greater in a sanatorium, where not only the therapeutic appliances of the dispensary are open to him, but, in addition, the inestimable advantages of living in perfectly pure air, of regulated rest and exercise, and abundance of good, nourishing food.

Of course, we all know that it is difficult to persuade those who suffer from early phthisis that they are sufficiently ill to go to a sanatorium, and they, naturally, jump at the prospect of being treated at their own homes and being cured of their malady with but little dislocation of their daily routine.

It is well known to the members of our profession that the objects of the Queen Victoria Homes are to treat consumptives in an early stage of the disease.

The results of treatment in such cases by the modern methods of the sanatorium—graduated exercises, and, in suitable cases, tuberculin treatment, together with open-air living and abundance of good, nourishing food—are known by all those engaged in such work to be most satisfactory.

There are two ways in which the difficulty of securing early, suitable cases may be overcome, and they are, first, the education of the community in the nature, causes and prevention of consumption, and second, the proper co-ordination of all the various efforts that are being taken to deal with the tuberculosis problem.

There are two institutions at present working in Sydney which have an opportunity of coming into contact with early cases, *viz.*, the Anti-Tuberculosis Dispensary at Hay Street, and the Tuberculosis Department at the Royal Prince Alfred Hospital.

Both these institutions have the opportunity of dealing with the "contacts" of advanced cases, for it is among such that the early cases are to be found.

With the establishment of these institutions the Board of the Queen Victoria Homes reasonably expected that from such sources many suitable cases would be forthcoming.

Unfortunately, such has not been our experience hitherto. Is it, Sir, unreasonable that we should look to these institutions to supply our needs, as far as possible?

It is, Sir, with the object of securing the influential support of your Journal that I am drawing attention to these facts.

What our Homes require in order that they may do satisfactorily the work for which they were established is a proper supply of suitable material—early cases.

The class of case we require is not that in which physical signs are readily recognizable, but rather that class of case where the practitioner has to hunt assiduously to detect the signs of a recent and localized deposit in one or other lung.

Such patients, as a rule, merely complain of languor, debility, and an undue proneness to tire on even slight exertion, perhaps a slight cough and some shortness of breath, and on examination a slight impairment of resonance or percussion under one or other clavicle or in the supra-spinous fossa on one or other side.

In such early cases, provided the patient is examined with the chest completely uncovered in a good light, it is usual to be able to detect some inequality in the movements of the upper part of the chest on the side affected.

Such patients may have little or no sputum, and in such cases the diagnosis may have to be established by X-ray screening and the application of the tuberculin test.

As patients in this early stage are not a danger to others as regards infection, being cases of closed tubercle, they may readily be admitted to a bed in one of the metropolitan hospitals with a view to the diagnosis being confirmed or otherwise.

We are all, I am sure, anxious to improve the lot of the consumptive, and to do our best to rid the community of this great scourge to humanity, and by attending to these details a big step forward will be made in restoring to the community many a valuable young life.

The advanced cases, of course, are quite another proposition, and their treatment should be undertaken in those institutions which the State provides for this purpose.

Hoping that you may lend your aid, Sir, in this matter,

Yours, etc.,

SYDNEY JAMIESON.

"Craignish," Macquarie Street,
Sydney, June 3, 1917.

CONSULTANT PATHOLOGISTS.

Sir,—On June 2, 1917, the Council of the New South Wales Branch published a resolution concerning pathologists. It contains what, in future, may be looked upon as the Council's definition of a consultant pathologist: a medical practitioner who does not undertake the immediate care of patients, that is to say, who does not attend, advise or prescribe for patients, otherwise than on behalf of, or in collaboration with, other practitioners.

This being of considerable interest to those of us who wish to be known as consultant pathologists, may I ask you to invite those who wish to come under this definition to inform you, with the view of publishing in the *Journal* a list of consultant pathologists?

Yours, etc.,

ALFRED E. FINCKH.

155 Macquarie Street, Sydney,
July 3, 1917.

SAFEGUARDING THE PRACTICES OF MEN ON ACTIVE SERVICE.

Sir,—I think it would be advisable and helpful to have a pronouncement of the Association's policy for the protection of the practices of men while absent on active service with the A.I.F. As there has been no statement of the ideas of the Council, I have been obliged to gather the opinions of various members on the subject. The conclusion drawn from these consultations has been that, while in Sydney and its environs a man may put up his plate with impunity chock-a-block with that of a man on active service, yet in the country should the same thing happen the prac-

tioner adversely affected would have some hope of finding redress on applying to the Association. If this is the case, the reasoning is manifestly absurd.

To come down to brass tacks, I should be glad to be informed whether, having been damaged in the aforesaid manner, I am at liberty to jump into the first country practice I know of where a man is serving his country in the A.I.F.?

Yours, etc.,

"INQUIRER."

Medical Appointments.

Dr. T. H. Lovegrove has been appointed Acting District Medical Officer and Public Vaccinator, Jarrahdale, Western Australia, during the absence of Dr. S. C. Moore on military service.

Dr. Joseph Foreman has been appointed a Member of the Board of Directors of the Royal Prince Alfred Hospital, Sydney, the Honourable Henry Yule Braddon having resigned.

The Board of Public Health, Victoria, has approved of the appointment of Dr. Thomas Garnet Sterling Leary as Officer of Health for the Borough of Sandringham, Victoria.

During the absence on active service of Dr. J. K. Couch, Dr. H. J. Lots has been appointed Acting Honorary Assistant Gynaecologist to the Perth Public Hospital, Western Australia.

Dr. J. Macdonald Allan has been appointed Acting District Medical Officer and Public Vaccinator, Moora, Western Australia, during the absence of Dr. W. S. Myles on military service.

Dr. Edward Ronald Armstrong MacDonnell has resigned his position as Assistant Medical Superintendent, Hospital for the Insane, Toowoomba, Queensland, and Dr. John Richard Talbot has been appointed in his stead.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xix.

Dunwich Benevolent Asylum and Inebriate Institution, Medical Superintendent.

University of Sydney, Lecturer and Chief Demonstrator of Physiology.

Government of Tasmania, Assistant Health Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
TASMANIA. (Hon. Sec., Bel- lerive, Tasmania.)	Medical Officers in all State-aided Hospitals in Tasmania.
VICTORIA. (Hon. Sec., Medi- cal Society Hall, East Melbourne.)	Brunswick Medical Institute. Bendigo Medical Institute. Prahran United F.S. Dispensary. Australian Prudential Association Pro- prietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.

Branch.	APPOINTMENTS.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Ade- laide Street, Bris- bane.)	Medical Officers to the Selwyn Hos- pital, North Queensland. Brisbane United Friendly Society In- stitute. Warwick Hospital.
SOUTH AUS- TRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
WESTERN AUS- TRALIA. (Hon. Sec., Health Department, Perth.)	All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society, F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Parramatta, Penrith, Auburn and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wall- send.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wel- lington.)	Friendly Society Lodges, Wellington, N.Z.

Diary for the Month.

- July 17.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
 July 18.—W. Aust. Branch, B.M.A., Branch.
 July 20.—Q. Branch, B.M.A., Council.
 July 20.—Eastern Suburbs Med. Assoc. (N.S.W.).
 July 21.—Northern Suburbs Med. Assoc. (N.S.W.).
 July 25.—Vic. Branch, B.M.A., Council.
 July 26.—S. Aust. Branch, B.M.A., Branch.
 July 27.—N.S.W. Branch, B.M.A., Branch.
 July 31.—N.S.W. Branch, B.M.A., Medical Politics Com-
 mittee; Organization and Science Committee.
 Aug. 1.—Vic. Branch, B.M.A., Branch.
 Aug. 3.—Q. Branch, B.M.A., Branch.
 Aug. 9.—Vic. Branch, B.M.A., Council.
 Aug. 10.—N.S.W. Branch, B.M.A., Clinical.
 Aug. 10.—S. Aust. Branch, B.M.A., Council.
 Aug. 14.—Tas. Branch, B.M.A., Council and Branch.
 Aug. 14.—N.S.W. Branch, B.M.A., Ethics Committee.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.